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Supreme Court, U.S.
FILED

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No. 05 -

OFFICE OF THE CLERK

In The

Supreme Court of the United States

DONNA SCHEIBLER, and
WILLIAM SCHEIBLER, her husband,
Insured/ plaintiff,
Petitioner,

v.

HIGHMARK BLUE SHIELD,
Insurer/ defendant,

THOMAS J. HARDIMAN,
United States District Court Judge,

Respondents.

On Petition for *Writ of Certiorari* to the
United States Court of Appeals for the Third Circuit

Petition for *Writ of Certiorari*

Mary Ellen Chajkowski, Esq.
Petitioner's Counsel of Record
Pennsylvania ID# 86611
5510 Hobart Street
Pittsburgh, PA 15217
412-904-2222

QUESTIONS PRESENTED

I. Whether preemption of Petitioner's insurance claim constituted a 14th Amendment violation?

- a) Savings Clause exception for insurance laws;
- b) Preemption inequitable to 'plan' participants;
- c) Jurisdiction invoked in Barber denied here;
- d) Respondent Answer: #6 *not ERISA* insurer.

ANSWER: Yes.

II. Whether lower courts modified or abridged the statutory rights and duties of the parties, in violation of the Fourteenth Amendment?

- a) Applied no fiduciary standard of review;
- b) Made procedural rulings in *bias* or *error*;
- c) Incorrectly applied law to dismissal;
- d) Abridged right to amend federal claims;
- e) Incorrectly applied law on *recusa* motion.

ANSWER: Yes.

III. Whether assigning Writ of Mandamus to second panel of judges, with two appeals pending before first panel of judges in the underlying action, prejudiced Petitioner?

ANSWER: Yes.

Preemption of 42 Pa. C.S. s 8371 Bad Faith

Medical Insurance Claim
Rehearing *en banc* denied;
Writ of Mandamus on Recusal denied,
By the Court of Appeals for the Third Circuit.

PARTIES

DONNA SCHEIBLER, and
WILLIAM SCHEIBLER, her husband,
Insured/ plaintiff,

Petitioner,

v.

HIGHMARK BLUE SHIELD,
Insurer/ defendant,

THOMAS J. HARDIMAN,
United States District Court Judge,

Respondents.

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Black & Decker Plan v. Nord, 123 S.Ct. 1965 (2003).

Carey v. Phipus, 435 U.S. 247 (1978)

City of Philadelphia v. Lead Industries Assn., Inc., Nos. 92-1419, 92-1420, 92-1463 (3d Cir. 1993).

Coles, et al v. Street, 38 Fed. Appx. 829 (3d Cir. 2002).

Firestone Tire v. Bruch, 489 U.S. 101 (1989).

Fuentes v. Shevin, 407 U.S. 67, 81 (1972).

Pinto v. Reliance, 214 F3d 377 (3d Cir. 2000).

Quakenbush v. Allstate, 517 U.S. 707, 712 (1996).

Selkridge v. United of Omaha, V.I., 01-cv-00143, (3d Cir. 2004).

Smathers v. Multi-Tool, Inc./Multi-Plastics, Inc., 298 F3d 191, 199 (3d Cir. 2002).

Stratton v. E.I. Dupont De Nemours & Co., D.C. No. 02-cv-02131, (3d Cir. 2004).

CITATIONS TO OPINIONS/ORDERS BELOW

District court, 04-cv-1928, dismissed bad faith claim with prejudice, February 1, 2005.

District court, 04-cv-1928, denied reconsideration, March 11, 2005.

District court, 04-cv-1928, denied petition to amend the complaint, April 13, 2005.

District court, 04-cv-1928, denied reconsideration of petition to amend, April 25, 2005.

Appeal court, No. **05-1717**, order to submit statement of appellate jurisdiction, due March 18, 2005.

Appeal court, No. **05-1717** and **05-2527**, *sua sponte* order to consolidate and dismiss the appeals, SLOVITER, FUENTES, NYGAARD, Circuit Judges.

JUDGMENTS TO BE REVIEWED (Rule 12.4)

Appeal court, No. **05-3769**, dismiss petition for *Writ of Mandamus* on Recusal, August 18, 2005.
RENDELL, FISHER, VAN ANTWERPEN,
Circuit Judges.

Appeal court, No. **05-1717** and **05-2527**, deny uncontested Rehearing *en banc*, September 19, 2005.
SCIRICA, Chief Judge, SLOVITER, ALITO, ROTH,
McKEE, RENDELL, BARRY, AMBRO, FUENTES,
SMITH, FISHER, VAN ANTWERPEN,
*NYGAARD, Circuit Judges.

*Judge Nygaard's vote is limited
to panel rehearing only.

JURISDICTIONAL STATEMENT

Orders to be Reviewed

Appeal court, No. 05-3769, August 18, 2005
Appeal court, 05-1717 / 05-2527, September 19, 2005

Statutes Conferring Jurisdiction

Rules of the Supreme Court of the United States:

Rule 10(a) The Third Circuit Court of Appeals has sanctioned such a departure by a lower court, as to call for an exercise of this Court's supervisory power.

Rule 10(c) The Third Circuit Court of Appeals has decided an important federal question in a way that conflicts with relevant decisions of this Court.

Rule 11 A review of the pleadings will show that this case is of such imperative public importance as to require immediate determination in this Court.

Rule 12.4 Petitioner seeks review on two judgments to the same court and involve identical or closely related questions.

The Supreme Court shall have appellate jurisdiction, both as to law and fact, with such exceptions, and under such Regulations as the Congress shall make.
U.S.C.A. Const. Art. III s2, cl.2.

Case review by *Certiorari*. 28 U.S.C. §1254 (1988).

U.S. Const. Amend. XIV, section 1.

42 Pa. C.S. s8371

PA Rules of Professional and Judicial Conduct.

PA and Federal rules of civil procedure.

Statement of the Case

Preemption of 42 Pa. C.S. s8371 Bad Faith Law

A panel of this appeal court preempted a bad faith insurance claim based on policy language in an employer's disability policy. Barber v. Unum Life Ins. Co. of America, 383 F.3d 134 (3d Cir. 2004). The lower courts here affirmed ERISA preemption of Petitioner's bad faith claim based on policy language.

Petitioner's medical records and letters from six treating physicians were never considered by Respondent or the lower courts, a departure from precedent in this circuit. Stratton v. E.I. Dupont De Nemours & Co., D.C. No. 02-cv-02131, (3d Cir. 2004); and contrary to the controlling authority from this court: "Plan administrators may not arbitrarily refuse to credit a claimant's reliable evidence, including the opinions of a treating physician." Black & Decker Disability Plan v. Nord, 123 S.Ct. 1965, 1967 (2003). Petitioner co-pays for benefits.

Department of Labor regulations requiring *plan* due process have been upheld by this court, in cases where medical insurance claims have been preempted. Aetna Health Inc. v. Davila, 539 U.S. 986, 124 S.Ct. 2488 (2004). Respondents' 'draft' plan is unenforceable, raising questions of fact:

- 1) Whether the 'draft' plan was qualified; and
- 2) Whether the plan offers procedures that afford a reasonable opportunity for full and fair review of dispositions adverse to claimants.

See *Petition for Reconsideration*, Appendix II, 18.

Petitioner filed the bad faith claim and Motion for Summary Judgment in state court. Appendix II, 75/91. "Preemption applies to a state statute if it provides a form of ultimate relief in a judicial forum." Barber at 140. Respondent filed for Removal, Appendix III, 53.

Scheibler v. Highmark
Count I ERISA
Count II 42 Pa. C.S. s8371 Bad Faith

Complaint filed December 23, 2004, 04-cv-1928;
Motion to Dismiss January 13, 2005;
Order on Motions Practice January 14, 2005;
Dismissal granted February 1, 2005;
Reconsideration denied, March 11, 2005;
Appealed at No. **05-1717**.

Uncontested petition to amend April 10, 2005;
Petition to amend denied April 13, 2005;
Uncontested petition for reconsideration;
Petition for reconsideration denied April 25, 2005;
Appealed at No. **05-2527**;

Order to file statement jurisdiction March 18, 2005;
Order *sua sponte* consolidated **05-1717 / 05-2527**;
and dismissed both appeals;
Sloviter, Fuentes, Nygaard, Circuit Judges.

Motion for Judicial Recusal opposed;
Writ of Mandamus uncontested;
Mandamus motion denied August 18, 2005;
By second panel at No. **05-3769**;
Rendell, Fisher, Van Antwerpen, Circuit Judges.

Uncontested petition rehearing *en banc*;
Rehearing *en banc* denied; September 19, 2005
Present: Scirica, Chief Judge, Sloviter, Alito, Roth,
McKee, Rendell, Barry, Ambro, Fuentes, Smith,
Fisher, VanAntwerpen, Nygaard*, Circuit Judges.
***J. Nygaard's vote limited to panel rehearing only.**

Medical Insurance Claim

Respondent acknowledged it received a January 2004 request for payment approval of Petitioner's medically necessary surgery.

Treating physician letters attributed Petitioner's need for oral surgery to extensive radiation treatments that administered for his tonsillar carcinoma and said surgery was medically necessary.

In a letter to Respondents, Dr. Rendulich attributed William Scheibler's caries to *xerostomia*:

"Radiation induced caries should be treated as a late effect medical condition resulting from radiation therapy. Having hyperbaric oxygen prior to dental extractions would significantly decrease his risk of *osteoradionecrosis*, which, as you know, can be quite extensive in nature, resulting in the loss of jaw and Significant dysfunction and deformity, requiring multiple operations to correct." See Appendix II, 2.

Respondent approved coverage for pre-op and post-op hyperbaric oxygen treatment and Petitioner traveled forty miles each way [Monday through Friday - four weeks] to hospital treatments, preparing for extraction surgery. Respondent refused to pay for 'office surgery' extraction and Petitioner appealed.

Respondents callously placed its insureds in a medical and economic state of emergency by denying a reasonable request for medically necessary surgery.

Respondents know that Petitioner's evidence will prove this assertion and attempts to cap its liability under the ambit of ERISA, by moving to preempt the insurance claim brought under the - Pennsylvania Bad Faith Statute, a cause of action to recover punitive damages.

Summary of the Argument

Respondent denied payment based on policy language and did no individual review of Petitioner's medical records. Lower court orders here effectively:

- a) Affirmed policy language as controlling, over claimant's evidence of medical necessity;
- b) Departed from precedent, prejudiced claimant;
- c) Failed to apply arbitrary & capricious standard of review, and affirmed inconsistent fiduciary decisions on Petitioner's medical evidence;
- d) Inequitably denied Petitioner the interlocutory jurisdiction it exercised in Barber to review 42 Pa. C.S. s8371, the same state law;
- e) Failed to exercise pendent jurisdiction, pursuant to ERISA's saving clause exception;
- f) ERISA participant bad faith claim inequitably barred; as non-plan claimants are not barred;
- g) Denied Petitioner's statutory due process on bad faith claim, a 14th Amendment violation;
- h) Contradicted Highmark's pleading Answers: [5. Contract - 6. Denied it is ERISA insurer.]

Respondents' state reimbursement subsidy is a factor warranting a fiduciary review, where it is alleged that subsidized medical services were paid/unsubsidized services were denied, on same coverage and claim, an unlawful restraint on Petitioner's medical care.

Judicial recusal denied, warrants procedural review.

Argument

State interest in regulating insurance extends beyond Petitioner's claim. Malpractice rates for physicians will rise exponentially if courts override the ERISA saving clause to preempt a neutral statute regulating insurance. This statute was enacted fifteen years after ERISA, as a civil enforcement deterrent:

"...mandating accountability on the part of all insurance companies for any frivolous or unfounded refusal to provide coverage in accordance with an applicable policy of insurance." 42 Pa.C.S. s8371.

I. Preemption of Petitioner's Insurance Claim constituted a 14th Amendment violation.

Respondent acknowledged receipt of medical necessity letters from Petitioner's treating physicians yet denied coverage offering no evidence of a medical basis for denial. This appeal court elected to preempt a state insurance claim, waiving appellate jurisdiction, which effectively affirmed the Respondents' denial of coverage, contrary to material factors. Respondents' decision is unsupported by medical evidence and lacked medical review or alternatives, it cited no appeal procedure, and made conflicting payments. There is no evidence, documentary or in practice, of Respondents' standing as a qualified ERISA *plan*, an unwelcome departure from precedent in this circuit; Stratton v. E.I. Dupont De Nemours & Co., D.C. No. 02-cv-02131, (3d Cir. 2004); contrary to controlling authority from this court: "*Plan* administrators may not arbitrarily refuse to credit a claimant's reliable evidence, including the opinions of a treating physician." Black & Decker Disability Plan v. Nord, 123 S.Ct. 1965, 1967 (2003). Respondents' standing and failure to comply with ERISA labor regulation; and Petitioner's statutory due process are issues that merit review. Aetna v. Davila, 539 U.S. 986 (2004).

a) Saving Clause Exception.

Preemption doctrines do not take supremacy over express ERISA saving clause provisions, insurance, securities and banking laws are constitutionally reserved to state authority. Respondent filed a Motion to Dismiss Petitioner's bad faith claim based on preemption, raising no constitutional challenge to the statute. Absent a constitutional conflict of law, federal courts have pendent jurisdiction.

Petitioner's record pleadings and motions allege facts to support exercise of pendent federal and state jurisdiction. Medical coverage claims are often heard in federal court, at the court's discretion.

Pendent jurisdiction to hear a state insurance claim with an ERISA claim cannot be discretionary where an insurer funds its operation by accepting medical reimbursement subsidy from the state. The undisputed Complaint allegation that Respondent requested and accepted full state reimbursement for medical services paid by Petitioner appear to ground jurisdiction as pendent, not in conflict with ERISA.

b) Preemption inequitable to 'plan' participants.

The lower courts preempted Petitioner's bad faith claim based on Respondents' unsupported assertion that its decisions were made pursuant to an employer 'plan'; a Fourteenth Amendment violation of the insurance statute and ERISA saving clause.

It was an inequitable exercise of jurisdiction, as courts do not preempt bad faith claimants that are not participants of an employer plan. Unconstitutional preemption of Petitioner's bad faith claim was also contrary to public policy.

It would be inequitable public policy for states to pay hospital reimbursement on publicly funded hospital claims using the medical necessity standard; concurrent with paying hospital reimbursement on *plan* participant claims using a policy language standard evaluating the same medical evidence.

Petitioner co-paid medical insurance premiums at rates established by Respondent and was denied coverage. Petitioner then paid for surgery months removed from approved pre-op 'reatments, that were intended to improve healing. Respondents' willful delay and inaction unnecessarily compounded Petitioner's pain and difficulty with dentures.

Respondent did not dispute or address Petitioner's allegation that it accepted reimbursement for surgery paid by Petitioner, a breach of legal duty and a violation of public policy that merits an exercise of this Court's supervisory power.

c) Inequitable exercise of appellate jurisdiction.

This appeal court chose not to grant an uncontested request for interlocutory appeal; an inequitable exercise of jurisdiction, where a panel of the same appeal court permitted interlocutory appeal to decide the Barber (2004) bad faith claim on the same statute. The lower courts erred in the standard of review it applied. Petitioner, a protected person under ERISA and this statute regulating insurance, should have had his claim construed *strict scrutiny* and *pari materia* with ERISA.

If upheld, preemption, as applied here, opens the door to insurers who deny medical coverage based on exclusionary policy language even when it is contrary to medical advice of treating physicians, an unconscionable departure from case precedent. Id.

d) Conflicts in the Pleadings

The court statement adopting Respondents' bald assertion, Appendix I, Transcript, 9a, that Respondent has ERISA standing is contradicted by pleading Answers, in Appendix III, 17. See paragraph 5, where Respondent relies on a contract, it did not attach. In paragraph 6, Respondent denies it is an ERISA insurer, it denies ERISA statutory language in other paragraphs and it filed Removal without attaching any plan documents. Appendix III, 53.

Respondent Highmark came sabre rattling to state court with an undocumented, bald assertion that it had standing to intervene and recover \$250,000 hospital expenses paid through a proffered 'plan' and withdrew its appeal when it came time to produce evidence of ERISA standing. McGreevy v. Taylor Services, et al, GD 04-018842, Allegheny County Court of Common Pleas, Pennsylvania.

II. The lower courts failed to enforce the parties' statutory rights and duties, in violation of the Fourteenth Amendment.

Petitioner requests a *Writ of Certiorari* from appeal court orders preempting and dismissing the bad faith insurance claim prior to the close of pleadings.

a) Fiduciary Standard of Review

Respondents expressly reserve discretionary authority to determine eligibility for benefits and to construe plan terms. Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 102 (1989), which warrants an arbitrary and capricious standard of review. *Id.* at 111. Respondent both funds and administers benefits, a conflict that warrants a heightened form of *arbitrary and capricious* standard of review. Pinto v. Reliance, 214 F.3d 377, 378 (3d Cir. 2000).

Respondents failure to investigate, litigate or settle this January 2004 claim, is inconsistent with an exercise of discretion by a fiduciary acting free of the interests that conflict with those of beneficiaries.

Pinto, 214 F.3d at 391, evidence of bad faith. Factors used to decide severity of conflict: 1) sophistication of the parties; 2) information accessible to the parties; 3) financial arrangements; 4) status of the fiduciary. Id.

Petitioner is employed in the factory position held by her husband prior to his disability and reports no corporate interests under the disclosure rules.

District court failed to implement F.R.P. 26 and corporate disclosure. The following information about Respondent was reported in local news media or produced by Respondent in actions in state court:

- a) Respondents own medical lines of business trading under various names;
- b) Respondents enter affiliate contracts giving rise to fiduciary conflict;
- c) Respondents' agent-compensated products are endorsed by associations;
- d) Respondent Highmark filed no disclosure on its dental insurance subsidiary;
- e) Respondent Highmark attempts to add Keystone Blue to the caption, without a motion or hearing. See Appendix III, 51;
- f) Highmark insures 2.8 million in W.Pa., sixty percent of region's health insurance.

In 2004, Respondents reported:

- a) Over two billion dollars in reserve;
- b) Over three hundred million dollars profit;
- c) Paid its chief executive 1.7 million dollars;
- d) Paid ten top executives 10 million dollars;
- e) Its wholly owned dental subsidiary earned over one billion dollars in 2004 revenue.

Respondents' policy language denial of this dental surgery claim was contrary to the medical evidence, which Respondent acknowledged receiving from Petitioner's treating physician. Respondents' decision to deny coverage for Petitioner's dental surgery constituted an ordinary person understanding of 'bad faith' and possible self-dealing. An untenable precedent, as Respondent's dominant position in the region's health care market is used to define contract terms with employers and premium rates for insureds.

b) The courts failed to enforce rules of procedure.

The lower courts failed to enforce basic rules of civil procedure, a breach of duty under the codes of professional and judicial conduct. Judicial exercise of authority consistently failed to construe the law in favor of Petitioners.

Respondent Highmark's untimely Answer and failure to respond to material bad faith and ERISA allegations were not construed in favor of Petitioner.

The court issued an order then expanded time frames in favor of Respondents, see Appendix II, 39. It entered *sua sponte* rulings adverse to Petitioner on uncontested requests to appeal and amend. Refusing to permit amendment at this stage has no legal basis whatsoever. It was an abuse of discretion for the appeal court to *sua sponte* consolidate the appeals at 05-1717 and 05-2527 and dismiss them without incorporating some reference to Petitioner's statutory, procedural and constitutional rights. It was capricious disregard of Petitioner's rights for the appeal court to issue an order for statements of appellate jurisdiction and then waive jurisdiction inequitably with its panel in Barber, on the same statute.

c) Lower Courts Incorrectly Applied the Law.

"In the procedural context of a Motion to Dismiss, we accept the factual allegations contained in the Amendment Complaint as true and plaintiff receives the benefit of all reasonable inferences to be drawn therefrom. See Angelastro v. Prudential-Bache, 764 F.2d 939, 944 (3d Cir.), cert. denied, 474 U.S. 935, (1985). We may not affirm the dismissal of the complaint unless plaintiffs can prove no set of facts that would entitle them to relief. City of Philadelphia v. Lead Industries Assn., Inc., Nos. 92-1419, 92-1420, 92-1463, (3d Cir. 1993), *citing* Conley v. Gibson, 355 U.S. 41, 45-46, (1957). Respondents filed no denials of material complaint allegations.

"Procedural due process rules are meant to protect persons not from deprivation, but from mistaken or unjustified deprivation of life, liberty or property." U.S.C.A. Const. Amend. 14. Carey v. Phipps, 435 U.S. 247 (1978) *citing* Boddie v. Connecticut, 401 U.S. 371, 375 (1971). "The right to procedural due process is 'absolute' in the sense that it does not depend upon the merits of a claimant's substantive assertions, and because of the importance to organized society that procedural due process be observed, we believe that the denial of procedural due process should be actionable without proof of actual injury." Id. Defendants elected not to litigate Plaintiff's bad faith claim in federal court, creating an undue economic prejudice to Plaintiff. This court has jurisdiction to review constitutional and legal errors.

Appellant reasonably believes the appeal court erred in relying on Quakenbush v. Allstate, 517 U. S. 707, 712 (1996), as the holding was limited to actions seeking common-law damages that are in federal court by way of diversity jurisdiction. Coles, et al v. Street, 38 Fed. Appx. 829 (3rd Cir. 2002).

d) The court abridged Petitioner's right to Amend.

Under the Fourteenth Amendment, due process mandates that once a state has created rights or benefits, these benefits may not be stripped away without due process of law. Fuentes v. Shevin, 407 U.S. 67, 81 (1972). Plaintiff has a statutory right to be heard on the 'bad faith' claim. Without an opportunity to be heard, Defendants are unjustly enriched at Plaintiffs expense.

The constitutional right to be heard is a basic aspect of the duty of government to follow a fair process of decision-making when it acts to deprive a person of his possessions. The purpose of this requirement is not only to ensure abstract fair play to the individual. Its purpose, more particularly, is to protect his use and possession of property from arbitrary encroachment-to minimize substantively unfair or mistaken deprivations of property, a danger that is especially great when the State seizes goods simply upon the application of and for the benefit of a private party. So viewed, the prohibition against the deprivation of property without due process of law reflects the high value, embedded in our constitutional and political history, that we place on a person's right to enjoy what is his, free of governmental interference. Id.

Respondents' failure to fully investigate, litigate or resolve this claim is evidence of statutory bad faith.

f) Incorrect Application of Judicial Recusal

Constructive Notice of Department of Labor regulations concerning qualified plan procedures and medical care claims must be imputed to Respondents. Aetna Health Inc. v. Davila, 539 U.S. 986, 124 S.Ct. 2488 (2004). Actual Notice of Petitioner's claim was made on Respondents' control group: by appeal and elected representative inquiry, correspondence from counsel and December 2004 lawsuit, to no avail. Petitioners reasonably believe statutory rights to due process were abridged by the district court, in *bias* or legal error, and filed a Motion for Recusal, and later an Appeal Court *Writ of Mandamus*, which were denied in error.

Respondents, noting the court's apparent *bias*, tapped into the court's pattern of *animus* by using inflammatory terms to describe Petitioner's counsel as 'brazen' and Petitioner as 'flouting' the law, in its Notice of Removal and Motion to Consolidate. See Appendix III, 53/57.

The appeal court stated there is no *estoppel* and waived appellate jurisdiction, See Appendix I, 13, a conundrum for the parties and confounding to the understanding and common sense of ordinary people.

The courts here gave no explanation for the denials, further prejudice to Petitioner and contrary to this appeal court's precedential decision in Selkridge, where the court held that there was basis for judicial recusal, then addressed the merits of the case to find no prejudice based on failure to timely Amend. Selkridge v. United of Omaha Life Insurance Company, on appeal from the District Court of the Virgin Islands, 01-cv-00143, (3d Cir. 2004).

An award may be vacated where it is shown that there was fraud, partiality, or other misconduct or where it violates a specific command of some law, or, where the award is inconsistent with public policy." W.D. 78 cv 791 H, Judge Diamond *citing* Black v. Cutter Laboratories, 43 Cal. 2d 788, 798, 278 P. 2d 905, 911 (1953).

III. Two panel prejudice to Petitioner

This appeal court prejudiced Petitioner when it assigned the Writ of Mandamus to a second panel of circuit judges while two appeals were pending before a first panel of circuit judges assigned to review the underlying action in the same circuit.

The lower courts issued no opinions or findings incorporating merits of Petitioner's claims and appeals or procedural misfeasance of the district court in denying reasonable petitions to amend the complaint to include federal claims. Selkridge *supra*.

CONCLUSION

WHEREAS, lower courts failed to apply the correct standards of review; failed to enforce statutory rights and responsibilities of the parties; failed to correctly apply the law; and unconstitutionally preempted an insurance claim, inconsistent with public policy, in violation of 14th Amendment rights, Petitioner requests a *Writ of Certiorari* to review legal errors of imperative public importance.

Respectfully submitted,

11/15/05

Mary Ellen Chajkowski, Esquire
Counsel for Petitioners

(2)

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HIGHMARK BLUE SHIELD,
Insurer, defendant,

THOMAS J. HARDIMAN,
United States District Court Judge,

Respondents.

On Petition for *Writ of Certiorari* to the
United States Court of Appeals for the Third Circuit

Appendix I – Court Orders and Transcripts

Mary Ellen Chajkowski, Esquire
Petitioner's Counsel of Record
Pennsylvania ID# 86611
5510 Hobart Street
Pittsburgh, PA 15217
412-904-2222

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JUDGMENTS TO BE REVIEWED (Rule 12.4)

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SCIRICA, Chief Judge, SLOVITER, ALITO, ROTH, McKEE, RENDELL, BARRY, AMBRO, FUENTES, SMITH, FISHER, VAN ANTWERPEN, *NYGAARD, <u>Circuit Judges</u> .	

*Judge Nygaard's vote is limited to panel rehearing only.

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**IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF PA**
Civil Action No. 04-1928

**DONNA SCHEIBLER and
WILLIAM SCHEIBLER, her husband,**
Plaintiffs,

v.
HIGHMARK BLUE SHIELD,
Defendant.

ORDER ON MOTIONS PRACTICE

The parties shall submit to the following rules in making and responding to motions on any case assigned to this member of the Court:

1. A motion shall state the factual and legal grounds for said motion, and shall be accompanied by a brief in support. A brief in support shall not exceed twenty (20) pages in length. No briefs are required for discovery motions, motions for extension of time and motions for continuance.

2. Responses to non-dispositive motions shall be filed within (5) days, not to exceed five (5) pages. No reply briefs to non-dispositive motions are permitted without leave of Court. Responses to dispositive motions shall be filed within twenty (20) days. Responsive briefs are limited to ten (10) pages in length. Reply briefs are permitted in dispositive motions, and must be submitted within ten (10) days of service of the response and are not to exceed five (5) pages. Sur reply briefs are not to be filed without leave of Court and will be limited to five (5) pages, if leave is granted. No briefing schedule will issue.

3. Oral argument will not be scheduled unless the Court determines that it is necessary. An order will be issued should the Court deem oral argument necessary.

4. Courtesy copies of all motions and briefs shall be forwarded to chambers. Voluminous exhibit binders should be omitted as they are available from the file maintained by the Clerk of Court.

5. Counsel should be familiar with this Court's Practices and Procedures (see Court Practices and Procedures at www.pawd.uscourts.gov, link "court practice".)

SO ORDERED this 14th day of January, 2005

/s/ Thomas M. Hardiman
United States District Judge

**IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF PA**
Civil Action No. 04-1928

DONNA SCHEIBLER and
WILLIAM SCHEIBLER, her husband,
Plaintiffs,

v.

HIGHMARK BLUE SHIELD,
Defendant.

ORDER

AND NOW, this 1st day of February, 2005, upon consideration of Defendant's Motion to Dismiss (Doc. No. 3), and Plaintiffs' opposition thereto, it is hereby ORDERED that said motion is GRANTED. Count II of Plaintiffs' Complaint (Pennsylvania Bad Faith Statute, 42 PA.C.S.A. § 8371) is DISMISSED WITH PREJUDICE.

/s/ Thomas M. Hardiman
United States District Judge

**IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF PA**

Civil Action No. 04-1928

DONNA SCHEIBLER and
WILLIAM SCHEIBLER, her husband,
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HIGHMARK BLUE SHIELD,
Defendant.

MEMORANDUM OPINION

I. Introduction

Plaintiffs Donna and William Scheibler bring this action claiming health care benefits under an employee benefits plan governed by the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. §§ 1001, et seq. In Count II of their Complaint, Plaintiffs set forth a claim for bad faith denial of an insurance claim under the Pennsylvania bad faith statute, 42 Pa.C.S.A. § 8371. Pending before the Court is the Defendant Highmark Blue Shield's (Highmark) Motion to Dismiss Count II.

II. Standard of Review

In reviewing a motion to dismiss under Rule 12(b)(6), the court accepts all well-pleaded allegations as true and views them in the light most favorable to the plaintiff. *In re Burlington Coat Factory Sec. Litig.*, 114 F.3d 1410, 1420 (3d Cir. 1997). "The issue is not whether a plaintiff will ultimately prevail but whether the claimant is entitled to offer evidence to support the claims." *Id.* (quoting

Scheuer v. Rhodes, 416 U.S. 232, 236 (1974)). Claims should be dismissed under Rule 12(b)(6) only if "it appears beyond doubt that the plaintiff can prove no set of facts in support of his claim which would entitle him to relief." Conley v. Gibson, 355 U.S. 41, 45-46 (1957). However, a court will not accept unwarranted inferences or sweeping legal conclusions cast in the form of factual allegations. Mitchell v. Cellone, No. 01-2028, 2003 U.S. Dist. LEXIS 22347, at *6 (W.D. Pa. November 17, 2003)(citing *miree v. Dekalb County, Ga.*, 433 U.S. 25, 27 n.2 (1977)).

III. Summary of the Facts

Donna Scheibler is an employee of ABB, Inc. (ABB) and is enrolled as a beneficiary of ABB's health care benefits. Ms. Scheibler contends that her husband, William, is also entitled to benefits under the plan and that Highmark provided the health care insurance for the plan. Mr. Scheibler was diagnosed with cancer for which he underwent radiation treatment in 1997. Plaintiffs claim that Highmark approved pre- and post-operative hyperbaric oxygen treatments to be performed in anticipation of William's oral surgery, but denied payment for the surgery itself. Plaintiffs claim that Highmark may have benefited by denying coverage for payment of hospital costs and later accepting reimbursement in excess of the agreed upon payment actually made. Plaintiffs seek to recover from Highmark damages that they allegedly suffered as a result of the denial of benefits. Plaintiffs appealed Highmark's denial of coverage, allegedly exhausting all administrative appeals. Count II of Plaintiffs' complaint purports to state a claim pursuant to the Pennsylvania bad faith statute, 42 Pa.C.S.A. § 8371.

IV. Discussion

The Court of Appeals for the Third Circuit recently held, in *Barber v. Unum Life Ins. Co. of America*, 383 F.3d 134 (3d Cir. 2004), that sections 502(a) and 514(a) of the Employee Retirement Income Security Act (ERISA) preempt claims under the Pennsylvania bad faith statute under both express preemption and conflict preemption. The Barber Court explained that conflict preemption applies to a state statute “if it provides ‘a form of ultimate relief in a judicial forum that added to the judicial remedies provided by ERISA . . . or . . . if it ‘duplicates, supplements, or supplants the ERISA civil enforcement remedy’.” *Id.* at 140. The Court of Appeals found that the Pennsylvania bad faith statute provided such relief and that it was therefore subject to conflict preemption. *Id.* at 140-41. In the alternative, the Third Circuit found that claims under the Pennsylvania bad faith statute are expressly preempted by Section 514(a) of ERISA. *Id.* at 141-44.

As a result, Plaintiffs’ bad faith claim in Count II is plainly barred under controlling law and must be dismissed.

An appropriate order follows.

/s/ Thomas M. Hardiman
United States District Judge
February 1, 2005

**IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF PA**
Civil Action No. 04-1928

DONNA SCHEIBLER and
WILLIAM SCHEIBLER, her husband,
Plaintiffs,

v.

HIGHMARK BLUE SHIELD,
Defendant.

ORDER

AND NOW, this 14th day of February, 2005,
Plaintiffs having filed in the above-entitled case a
Petition for Reconsideration, it is hereby ORDERED
that Defendant file a response to the motion on or
before February 24, 2005.

BY THE COURT:

/s/ Thomas M. Hardiman
United States District Judge

**IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF PA**

Civil Action No. 04-1928

DONNA SCHEIBLER and
WILLIAM SCHEIBLER, her husband,
Plaintiffs,

v.

HIGHMARK BLUE SHIELD,
Defendant.

ORDER

AND NOW, this 11th day of March, 2005, for the reasons stated on the record [03/10/05 Transcript], Count II of Plaintiffs' Complaint is dismissed with prejudice, Petition for Reconsideration is DENIED.

BY THE COURT:

Thomas M. Hardiman
United States District Judge

**IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF PA**
Civil Action No. 04-1928

DONNA SCHEIBLER and
WILLIAM SCHEIBLER, her husband,
Plaintiffs,

v.

HIGHMARK BLUE SHIELD,
Defendant.

ORDER

AND NOW, this 13th day of April, 2005, it is hereby
ORDERED that Plaintiffs' Petition for an Extension
of Time to Amend the Complaint, docket no. 23, is
DENIED.

BY THE COURT:

Thomas M. Hardiman
United States District Judge

**IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF PA**
Civil Action No. 04-1928

DONNA SCHEIBLER and
WILLIAM SCHEIBLER, her husband,
Plaintiffs,

v.

HIGHMARK BLUE SHIELD,
Defendant.

ORDER

ORDER

AND NOW, this 25th day of April, 2005, upon consideration of Plaintiffs' Petition for Reconsideration of the April 13, 2005 Court Order Denying Plaintiffs' Petition for an Extension of Time to Amend Complaint (Doc. No. 25), for the reasons stated on the record, it is hereby ORDERED that said Petition is DENIED.

BY THE COURT:

/s/ Thomas M. Hardiman
United States District Judge

**UNITED STATES COURT OF APPEALS
FOR THE THIRD CIRCUIT**

Donna Scheibler; and
William Schiebler, her husband,
Appellants.

v.

Highmark Blue Shield,
Appellee.

Re: Docket No. 05-1717
Scheibler vs. Highmark Blue Shield
D.C. Civil No. 04-cv-1928

Dear Counsel:

This will advise you that the within appeal will be submitted to a panel of this Court for possible dismissal due to a jurisdictional defect.

It appears that this Court lacks jurisdiction for the reason that the notice of appeal is taken from an order which is not final within the meaning of 28 U.S.C. section 1291 and has not been certified pursuant to Rule 54(b), Fed.R.Civ. P.

The Court DIRECTS that all parties respond IN WRITING (original and 3 copies with a certificate of service). The responses are to be RECEIVED in the Clerk's Office not later than 3/18/05. The responses may be in either pleading or informal letter form.

If counsel fail to respond, the matter will be submitted to the Court without the requested response(s). You are advised that failure to respond may result in the imposition of sanctions by the

Court. Parties who do not intend to participate in the appeal are directed to so notify the Court in writing (original and 3 copies with a certificate of service).

This notice will not stay the time for making any filings or submissions required by the rules of this Court nor will it stay entry of a briefing schedule.

Very truly yours,

/s/ Marcia M. Waldron
Clerk

By: Kelly A. Glaum
Case Managing Attorney

**UNITED STATES COURT OF APPEALS
FOR THE THIRD CIRCUIT
Nos. 05-1717 & 05-2527**

(Western District of PA Civil No. 04-cv-01928)

Donna Scheibler; and
William Schiebler, her husband,
Appellants.

v.

Highmark Blue Shield,
Appellee.

SLOVITER, FUENTES, NYGAARD, Circuit Judges.

1. Clerk's Submission for possible dismissal due to jurisdictional defect.
2. Response by Appellee, Highmark Blue Shield
3. Response by Appellants, Donna Scheibler and William Scheibler
4. Response by Appellants, Donna Scheibler and William Scheibler in No. 05-2527

Tonya Wyche, Case Manager

ORDER

The orders appealed do not end the litigation as to all claims and all parties. Since no entry of final judgment has been made under Fed.R.Civ.P. 54(b) and since the orders appealed do not "end the litigation on the merits and leave nothing for the court to do but execute final judgment," Appellant's appeals are not final or appealable at this time under 28 U.S.C. § 1291. *Quakenbush v. AllState Ins. Co.*, 517 U.S. 706, 712 (1996).

The orders appealed also have not been certified as immediately appealable under 28 U.S.C. § 1292(b) nor do they fall under the collateral order exception to the final judgment rule. See *Digital Equip. Corp v. Desktop Direct, Inc.*, 511 U.S. 863, 867-68 (1994). Appellant's appeals are therefore dismissed for lack of appellate jurisdiction.

By the Court,

/s/ Julio M. Fuentes
Circuit Judge

Dated: July 26, 2005

JUDGMENTS TO BE REVIEWED (R.12.4)

UNITED STATES COURT OF APPEALS
FOR THE THIRD CIRCUIT

Nos. 05-3569

(Western District of PA - Civil No. 04-cv-01928)

Donna Scheibler; and
William Schiebler, her husband,
Appellants,

v.

Highmark Blue Shield,
Appellee.

RENDELL, FISHER, and VAN ANTWERPEN,
Circuit Judges.

Petition by Donna Scheibler and William Scheibler
for *Writ of Mandamus* to United States District Court
for the Western District of Pennsylvania.

/s/ Rebecca L. Simon, Case Manager

ORDER

The foregoing petition by Donna Scheibler and
William Scheibler for *Writ of Mandamus* is DENIED.

By the Court:

/s/ Franklin S. Van Antwerpen, Circuit Judge.

Dated: August 18, 2005

JUDGMENTS TO BE REVIEWED (R.12.4)

UNITED STATES COURT OF APPEALS
FOR THE THIRD CIRCUIT

Nos. 05-1717 & 05-2527

(Western District of PA - Civil No. 04-cv-01928)

Donna Scheibler; and
William Schiebler, her husband,
Appellants,

v.

Highmark Blue Shield,
Appellee.

SUR PETITION FOR REHEARING *EN BANC*

Present: SCIRICA, Chief Judge, SLOVITER,
ALITO, ROTH, McKEE, RENDELL, BARRY,
AMBRO, FUENTES, SMITH, FISHER, VAN
ANTWERPEN and NYGAARD*, Circuit Judges

**Judge Nygaard's vote is limited
to panel rehearing only.*

The Petition for Rehearing filed by the Appellants in the above-entitled matter, having been submitted to the judges who participated in the decision of this court and to all the other available circuit judges of the circuit in regular active service, and no judge who concurred in the decision having asked for rehearing, and a majority of the circuit judges of the circuit in regular service not having voted for rehearing, the Petition for Rehearing by the panel and by the Court en banc, is hereby DENIED.
BY THE COURT,

/s/ Julio M. Fuentes, Circuit Judge.

Dated: September 19, 2005

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF PENNSYLVANIA

DONNA SCHEIBLER, et al.,

Plaintiff,

vs.

Civil Action

No. 04-1928

HIGHMARK BLUE SHIELD,

Defendant.



Transcript of proceedings on March 10, 2005,
United States District Court, Pittsburgh, Pennsylvania,
before Thomas M. Hardiman, District Judge

APPEARANCES:

For the Plaintiff: Mary Ellen Chajkowski, Esq.

For the Defendant: Brian Fagan, Esq.

Court Reporter: Richard T. Ford, RMR, CRR
1023-B U.S. Courthouse
Pittsburgh, PA 15219
(412) 261-0802

Proceedings recorded by mechanical stenography; transcript
produced by computer-aided transcription

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1 (Proceedings held in open court; March 10, 2005).

2 THE COURT: Would counsel enter their appearance,
3 please.

4 MS. CHAJKOWSKI: My name is Mary Ellen Chajkowski,
5 I represent the Scheiblers at the Scheiblers versus Highmark
6 civil case.

7 MR. FAGAN: Brian Fagan, F-A-G-A-N, on behalf of
8 Highmark.

9 THE COURT: I just wanted to bring you in here to
10 explain what's going on in this case because there have been a
11 flurry of motions. Obviously I dismissed the bad faith count
12 that you filed, Ms. Chajkowski. The reason I did was the

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13 Third Circuit in the Barber case held that the Pennsylvania
14 bad faith statute is preempted by ERISA. So that count is --
15 cannot stand by any stretch of the imagination.

16 Now, if you believe that I have made that decision in
17 error, you can take that up with the circuit, but you can't
18 take it up with the circuit now while the case is still
19 pending. There are other counts in your case. So we are
20 going to have to adjudicate the whole case; then if you are
21 unhappy with the result, then you can take that issue up on
22 appeal.

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23 But I would caution you that you need to take a
24 careful look at the Barber case before you do that or else you
25 might be putting yourself in some degree of jeopardy with the

1 circuit because Barber clearly held that that statute is, the
2 bad faith statute, is preempted by ERISA. It is an issue that
3 has been percolating for a few years in the district courts.
4 There were a variety of decisions by the district courts.
5 Some held that it was not preempted; others held that it was
6 preempted. But the circuit just answered that question within
7 the last year.

8 MS. CHAJKOWSKI: Your Honor, if that were so, if
9 you wanted to leave it at that position where you keep out the
10 bad faith, I'd like to ask you to consider the things that I
11 raised in the petition for reconsideration, which are: On
12 their motion to dismiss they moved to dismiss based on ERISA

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13 preemption. Yet when they filed their answers and responses
14 to the petition for reconsideration and the complaint, they
15 are denying ERISA liability.

16 Also, even before they made responses, in my petition
17 for reconsideration I raised some factual questions. The
18 first being that the plan may not be a qualified plan. ERISA
19 may not apply here. If ERISA does not apply, then the bad
20 faith statute would apply.

21 My concern was --

22 THE COURT: If ERISA doesn't apply, what is the
23 federal question presented in your case?

24 MS. CHAJKOWSKI: Either antitrust or securities or
25 both.

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1 THE COURT: Has antitrust or securities been
2 pleaded?

3 MS. CHAJKOWSKI: Not yet, but the fact was I wanted
4 to plead the two obvious things first to see where it led, and
5 the fact is, Your Honor, Highmark owns a dental subsidiary, it
6 is wholly owned by Highmark, and they brought in a billion
7 dollars in income in 2004, and the fact is they are blanket
8 denials. If they don't include due process, if they don't
9 include the specificity required under the regulations of
10 ERISA, and if ERISA doesn't apply, then they are, you know,
11 across the board denying dental surgery.

12 In this case this was a medical qualified request and

13 it was not -- their answer in the letter they wrote to my
14 client May 17th said that their appeal was through ERISA. In
15 fact, the responses say they are denying ERISA. And the
16 documents that they provided in terms of a plan, it was not a
17 plan, it was a draft, Your Honor --

18 THE COURT: So you are saying they can't on the one
19 hand say ERISA doesn't apply and then at the same time say
20 ERISA preempts the bad faith.

21 MS. CHAJKOWSKI: Correct, Your Honor.

22 THE COURT: Let me hear from Mr. Fagan on that.

23 MR. FAGAN: Two things. The first thing, the
24 Plaintiffs themselves established that this is an ERISA plan
25 and it's evident on the facts of this case. They say it's an

1 employee benefits plan.

2 THE COURT: So you don't deny it is an ERISA plan?

3 MR. FAGAN: Not at all. It's definitely an ERISA
4 plan. It's a plan provided to Ms. Chajkowski's clients
5 through Donna Scheibler's employer. So it's an ERISA plan.

6 I think the confusion comes up, we've denied
7 liability under ERISA and also deny any liability for any
8 state law causes of action because they're preempted by ERISA.
9 But the issues of our liability remain, and they remain --

10 THE COURT: The ERISA case will go on.

11 MR. FAGAN: Certainly.

12 THE COURT: But the bad faith case won't go on

13 because of the Barber case.

14 MR. FAGAN: Correct. Simply by denying our
15 liability for the ERISA claim doesn't -- we haven't won the
16 case.

17 THE COURT: They are not saying -- he has just
18 represented on the record that it is an ERISA case, it is an
19 ERISA plan your client has rights under. So there is federal
20 question jurisdiction.

21 MS. CHAJKOWSKI: Your Honor, in the pleading when
22 they filed answers to the complaint they denied the specific
23 language under ERISA, and I pointed that out in my reply to
24 their response.

25 And also, Your Honor, if they didn't do the thing

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1 under ERISA, if they didn't give a written notice with
2 specificity to be understood by the participants that it
3 provides an appeal process, the document he is referring to
4 has no table of contents, no index, pages are not numbered,
5 and in going through every page I could not find the appeal
6 process or the procedure for written notice.

7 The Scheiblers didn't get written notice --

8 THE COURT: All of that goes to the merits of your
9 case, which you will have discovery, you will take
10 depositions, then we will adjudicate the case either on
11 summary judgment or at trial. So you can continue to go
12 forward with that.

13 MS. CHAJKOWSKI: Your Honor, could I ask one other
14 thing? Could you remove at least the "with prejudice" because
15 the "with prejudice" indicates that it was either litigated or
16 on the merits, and neither happened. There was no litigation
17 on the issue of --

18 THE COURT: On the bad faith?

19 MS. CHAJKOWSKI: Yes, Your Honor.

20 THE COURT: It is dismissed with prejudice, meaning
21 that the bad faith claim, you cannot state a claim for bad
22 faith because ERISA preempts it. So it has to be with
23 prejudice. If I said "without prejudice," then you could just
24 refile it again. But you can't file it again because the
25 Third Circuit has said no.

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1 If you think I'm misreading the Barber opinion, then
2 you can take that up with the circuit at the end of this case,
3 but you are going to have to do that then, not now. So I will
4 deny the motion for reconsideration.

5 MS. CHAJKOWSKI: Do you have any timetable? My
6 client is concerned with the time factor.

7 THE COURT: We can try this case as quickly as you
8 two can get the case ready to go. We can try it in August,
9 September, whenever you're ready.

10 MS. CHAJKOWSKI: So August would be the earliest
11 that it can be tried?

12 THE COURT: If there is some reason to try it

13 sooner and you are both ready, we can maybe try it in June or
14 July.

15 MS. CHAJKOWSKI: My client would like that,
16 Your Honor. Further, with leave to amend the complaint, in
17 your -- the information that's on the Internet, it says at
18 some point before discovery is concluded.

19 THE COURT: You want leave to amend?

20 MS. CHAJKOWSKI: Yes.

21 THE COURT: How much time do you need?

22 MS. CHAJKOWSKI: 30 days.

23 THE COURT: All right. I will give you 30 days
24 leave to amend, but you need to realize, you're saying
25 mutually contradictory things. You are saying you are going

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1 to file an amended complaint within 30 days and then you are
2 telling me you want to go to trial very quickly. Those two
3 things are inconsistent because they have a right to read your
4 complaint, respond to your complaint, take discovery. So I
5 will give you the 30 days to amend, but then you are looking
6 at a trial August, September at the very earliest.

7 MS. CHAJKOWSKI: If I choose not to amend at this
8 time, then we would proceed to discovery on the ERISA issue;
9 and then if this is not an ERISA qualified plan, then what
10 happens to the state claim of bad faith?

11 THE COURT: The state bad faith claim is gone.
12 It's dead on arrival because it's an ERISA plan. He has

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13 admitted, your adversary has admitted in open court on the
14 record this is an ERISA plan. So I am not going to be
15 persuaded by any arguments if he comes in here either orally
16 or in writing telling me it is not an ERISA plan. He has just
17 admitted it is.

18 MS. CHAJKOWSKI: Your Honor, he does that in the
19 statement, but that's not what they wrote in their pleadings.

20 MR. FAGAN: That is not exactly true. We just
21 denied liability.

22 THE COURT: You said that it's a plan, but you have
23 denied that you are liable under the plan.

24 MR. FAGAN: Correct.

25 THE COURT: That's the way I read their answer.

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1 MR. FAGAN: If we did something wrong, the
2 Plaintiffs still have the opportunity to prove it in trial.

3 THE COURT: All right. So do you want leave to
4 amend or not?

5 MS. CHAJKOWSKI: Well then you are saying we can go
6 to trial in June without an amendment --

7 THE COURT: If you don't amend, if it's a simple
8 case without 10 or 20 depositions, if you need three or four
9 depositions, then I could try to do the case in June.

10 MS. CHAJKOWSKI: I need time to consider whether I
11 should amend now or later then. But, Your Honor, with all due
12 respect, I think there are material questions of fact that

13 would preclude dismissal, and also the "with prejudice" aspect
14 was very prejudicial to the due process of my client. And the
15 Court does have a constitutional role in the enforcement of
16 ERISA. There was no --

17 THE COURT: The Court has a constitutional role?

18 MS. CHAJKOWSKI: Yes, Your Honor.

19 THE COURT: To do what the Third Circuit says.
20 Lawyers have a constitutional role to read Third Circuit cases
21 and not file pleadings that are directly contrary to
22 controlling law or else they risk Rule 11 sanctions. That's
23 why I brought you both in here to try to make clear before any
24 of you do anything that might get you sanctioned by Rule 11 to
25 be very careful to read the controlling law of the circuit.

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1 Because it doesn't matter what I think regarding ERISA
2 preemption.

3 What matters is the Third Circuit has said in the
4 Barber case that state law for bad faith insurance is
5 preempted by ERISA. And due process, material facts,
6 et cetera, none of that have anything to do with the fact that
7 the Third Circuit has clearly held that it is preempted. That
8 means you can't get out of the starting gate. You can't file
9 a Pennsylvania bad faith claim in an ERISA case. And your
10 adversary has conceded this is an ERISA plan. So for that
11 reason I have to deny the motion for reconsideration.

12 Your exceptions are on the record; and if you

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13 disagree with anything that I have done in this case, you can
14 appeal it after the case is over. But, again, I would ask you
15 not to appeal it in the middle of the case because that's
16 another thing that could get you hit with a Rule 11 sanction.
17 You don't file an interlocutory appeal in the middle of a
18 case. You have to wait until the case is over. All right?

19 MS. CHAJKOWSKI: Thank you, Your Honor.

20 (Record closed).

21

22 C E R T I F I C A T E

23 I, Richard T. Ford, certify that the foregoing
24 is a correct transcript from the record of proceedings in the
above-titled matter.

25 Richard T. Ford
Richard T. Ford

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IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF PENNSYLVANIA

DONNA SCHEIBLER, et al.,

Plaintiff,

vs.

HIGHMARK BLUE SHIELD,

Defendant.

Civil Action

No. 04-1928



Transcript of proceedings on April 25, 2005,
United States District Court, Pittsburgh, Pennsylvania,
before Thomas M. Hardiman, District Judge

APPEARANCES:

For the Plaintiffs: Mary Ellen Chajkowski, Esq.

For the Defendant: Brian Fagan, Esq.

Court Reporter: Richard T. Ford, RMR, CRR
1023-B U.S. Courthouse
Pittsburgh, PA 15219
(412) 261-0802

Proceedings recorded by mechanical stenography; transcript
produced by computer-aided transcription

1 (Proceedings of April 25, 2005; in chambers).

2 (Counsel present via telephone).

3 THE COURT: Good afternoon, folks.

4 MR. FAGAN: Good afternoon, Your Honor.

5 MS. CHAJKOWSKI: Hello.

6 THE COURT: We have Ms. Chajkowski and Mr. Fagan.

7 MR. FAGAN: Yes.

8 THE COURT: Okay. I received today a copy of
9 Plaintiffs' petition for reconsideration. I asked to have
10 this telephonic status conference as a result of this, and I
11 have the Court Reporter in chambers right now transcribing
12 this telephonic conference.

13 I guess I am still a little bit confused,
14 Ms. Chajkowski, as to the procedural posture of this case. I
15 indicated last time that you were here that your appeal to the
16 Court of Appeals for the Third Circuit was improper because it
17 was an interlocutory appeal and that if you think I made a
18 mistake in finding that the Pennsylvania bad faith statute is
19 preempted by ERISA, as held by the Court of Appeals in the
20 case of Barber versus UNUM, that you are certainly free to
21 take that issue up to the Circuit after your case was
22 concluded.

23 But your case is still pending here and yet at the
24 same time you are seeking appellate review. So for that
25 reason I denied your petition for an extension of time to

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1 amend the complaint because you had asked me to wait until the
2 Court of Appeals ruled on your appeal, and I didn't think it
3 would be appropriate to reward your client for something that
4 was done improperly as a procedural matter.

5 Now, I am always willing to give people time to amend
6 a complaint because amendments to complaints are to be freely
7 given, but I don't want to prejudice the Defendant based upon
8 what is, in my mind, plainly an improper appeal.

9 So would you respond to that, Ms. Chajkowski.

10 MS. CHAJKOWSKI: Well, I think the appeal speaks
11 for itself. There are constitutional reasons and Third
12 Circuit cases regarding fiduciary duty that were not

13 considered in the decision to dismiss the bad faith.

14 I am trying to hold on to the bad faith for my client
15 because they -- it would not be taxable, where if I go into
16 another federal statute at this time and get the same relief,
17 they would be faced with all kinds of taxes and other things
18 and it would take a number of years.

19 - The family has been distressed, as I have tried to
20 include in the pleadings, by the prolonged nature of this and
21 I believe that my pleadings speak for themselves. I would
22 like to hear what the Defendant has to say to the pleadings.

23 THE COURT: One of the things that is prolonging
24 this is you have taken this inappropriate appeal. I know you
25 want to hold onto the bad faith claim and I know that you want

1 to ask the Court of Appeals to reverse my decision regarding
2 the bad faith claim, and that's fine, I encourage you to do
3 that if that's what you wish to do, but you can't do it until
4 a final order is entered in this case.

5 MS. CHAJKOWSKI: Your Honor, there are reasons for
6 interlocutory appeal, and prejudice to the Plaintiff is one of
7 them. And when you eviscerate the bad faith claim, you
8 basically limit what can be discovered and what can be
9 introduced as evidence. So you handicap my clients from the
10 beginning. I think that's been pretty well set forth in my
11 pleadings. I still haven't heard what the Defendant has to
12 say.

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13 THE COURT: Well, Ms. Chajkowski, I guess I want to
14 make clear on the record that to the extent you're complaining
15 to anybody about the protracted nature of the proceedings,
16 that's going to be caused by this appeal. Because, you see, I
17 am not going to do anything with your case here until the
18 Court of Appeals rules on your appeal. I assume that they are
19 just going to send it back to me saying that they have no
20 jurisdiction because I haven't even entered a final order.

21 So I want to make sure you're aware that the delay is
22 caused by that appeal. Because I can't allow you to litigate
23 a case here in front of me while at the same time you're
24 pursuing an appeal to the Circuit. Do you understand that?

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25 MS. CHAJKOWSKI: Your Honor, this in this petition

1 for reconsideration, I raised the issue of subject matter
2 jurisdiction, and that issue can be raised any time, even
3 after a final verdict. Would it not make sense with judicial
4 economy to have all the cards on the table with the Rule 26
5 enforcement before we go anywhere? And why has it been
6 delayed all these months?

7 THE COURT: Because I can't even have a case
8 management conference -- you see, we don't begin discovery
9 until there is a complaint and an answer. There's been no
10 answer filed.

11 MS. CHAJKOWSKI: There was an answer filed,
12 Your Honor.

13 MR. FAGAN: Your Honor, there was an answer filed
14 on behalf of Defendants.

15 THE COURT: Well, but then the appeal --

16 MR. FAGAN: I think we have been held up by these
17 appeals and these other numerous motions filed on behalf of
18 Plaintiffs that have prevented the normal process that I think
19 we would get into with Rule 26 disclosures and the initial
20 status conference.

21 THE COURT: Ms. Chajkowski, the bottom line here is
22 that district courts and appellate courts don't hear a case at
23 the same time. Either I have jurisdiction or they have
24 jurisdiction.

25 MS. CHAJKOWSKI: That was why I asked that you

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1 permit the Plaintiff to amend after we hear from the Third
2 Circuit. Basically we're asking the Third Circuit to review a
3 decision that was made in November. Every free citizen in the
4 Third Circuit, whether it's health insurance or a contract for
5 disability, as there was in Barber -- and I don't see that the
6 Third Circuit would delay that because there may be numerous
7 people who are disadvantaged because the reading you have of
8 Barber would be different than the Third Circuit. I would
9 assume they would take that under review in a timely manner
10 for the benefit of all the public.

12b

11 I think this case with Scheibler presents legal
12 issues that merit appellate review so that the state and the

13 insurer can go on and do business in an ordinary good faith
14 manner.

15 THE COURT: All right. Well, you've made it clear
16 that you want to pursue this appeal at this time, and I am not
17 going to tell you you can't. I have already told you my view
18 of the matter regarding the fact that it seems to me to be
19 interlocutory and not appropriate, but obviously you disagree
20 with that and that's fine.

21 So go ahead and pursue your appeal, but in the
22 meantime I am not going to entertain any action in this case
23 while you are pursuing your appeal. I am going to deny this
24 petition for reconsideration; and if the Plaintiffs or the
25 Defendant file any motions in front of me, whether they relate

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1 to discovery or Rule 26 or anything, I'm going to reject them
2 out of hand because this case is now with the Court of
3 Appeals. And until the Court of Appeals sends it back down to
4 me, I'm not going to entertain any motions by either side.

5 MS. CHAJKOWSKI: Your Honor, do you understand by
6 doing that you're continuing the pattern that I laid out in
7 Paragraph 9 because the Defendant would have been, under your
8 order in February, they would have been obligated to -- it was
9 your January order that said within so many days they reply to
10 the petition, so the Court is taking action again before the
11 Defendant responds to the allegations put forward in the
12 petition for reconsideration.

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13 THE COURT: Well --

14 MR. FAGAN: I am actually confused, Your Honor, as
15 to what we haven't responded to, to tell you the truth.

16 MS. CHAJKOWSKI: Look at Paragraph 9 of the
17 document that was just filed on Friday.

18 THE COURT: Paragraph 9 of Plaintiffs' --

19 MS. CHAJKOWSKI: I am sorry, Paragraph 11. There
20 are a number of times where, before the due date for the
21 Defendant to respond, the Court intervened with an order, and
22 that would happen again here.

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23 The first thing the Plaintiff asked for was to have
24 the Court permit the Defendant to give an answer to that
25 petition. So you are calling to tell me you are going to file

1 an order again without an answer from the Defendant? Is that
2 what you're telling me?

3 THE COURT: I am reading Paragraph 11 right now.

4 Well, I guess there are a lot of things I could say
5 about Paragraph 11, I will just go through point-by-point I
6 guess would be the best way to do it. 168

7 The first statement that Plaintiffs' cause of action
8 has been inequitably handicapped and prejudiced by a series of
9 material sua sponte court actions and omissions does not
10 appear to me to be a correct statement at all.

11 Paragraph A indicates the complaint was filed on
12 December 23, 2004. Then it says, no enforcement of Rule 26

13 disclosures to date.

14 Rule 26 disclosures are not implicated upon the
15 filing of the complaint, so I am confused as to why that
16 statement is in Paragraph A.

17 Paragraph B says that the Defendant accepted service
18 on January 3, 2005, which is common after the complaint is
19 filed, the Defendant accepted service.

20 Ten days later, as reflected in Paragraph C, the
21 Defendant filed a motion to dismiss on January 13, 2005.

22 The very next day, as reflected in Paragraph D, on
23 January 14, 2005, this Court ordered the parties to submit to
24 its motions rules. I agree with that, at least that comports
25 with my recollection. 158

1 Then on January 28, 2005, the Plaintiffs filed their
2 opposition in response and the motion to deny. I don't know
3 what the motion to deny is. That's not --

4 MS. CHAJKOWSKI: Deny the motion to dismiss.

5 THE COURT: That's not a form of pleading that I
6 have -- that I am familiar with. But I understand that it
7 says it was an opposition in response, and I did take that
8 pleading to be Plaintiffs' opposition to the motion to dismiss
9 saying that ERISA did not preempt the bad faith claim.

10 Next, on February 1, 2005, it says, District Court
11 granted dismissal before response time lapsed. I am not sure
12 what that refers to.

13 MS. CHAJKOWSKI: Well, if you go to your order for
14 the motion -- the order on motions practice, you mentioned the
15 reply date and you say a reply brief must be submitted within
16 ten days. And sur-reply briefs are not to be filed without
17 leave of Court. The fact is, after we opposed their motion to
18 dismiss, I filed a -- I mean, you didn't permit them time to
19 respond to the things I raised in my response. So that's why
20 I mean sua sponte, it's sort of like the time hadn't passed
21 for them to even file their response.

22 THE COURT: Is that something that was objected to
23 by counsel, Mr. Fagan? Did you have any objection to my not
24 allowing you time to file a reply brief?

25 MR. FAGAN: No. And I think it would have been a

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1 sur-reply on our part, I believe, and we didn't seek leave for
2 that and I don't think the Court was -- or we were required to
3 file one. We didn't ask to. So it's a non-issue.

4 THE COURT: Well, it wouldn't have been a sur-reply
5 because you filed the initial brief, then Ms. Chajkowski filed
6 a response brief, and then --

7 MR. FAGAN: Well, a reply I guess.

8 THE COURT: Right.

9 MR. FAGAN: I don't think we were required to even
10 file the reply to her response.

11 THE COURT: All right.

12 MS. CHAJKOWSKI: Your Honor, I object to that

13 because when a party chooses not to -- first of all, the
14 response brief raised legal issues, Third Circuit and United
15 States Supreme Court cases that were not considered in the
16 briefs that were filed to dismiss, okay, and so basically they
17 raised certain issues, we responded to what they raised and
18 also gave other authority on Third Circuit and above that
19 would have applied to this case.

20 If they chose not to reply to that, it would have
21 been, in my view, better for the Court to wait for the
22 permissible response time before they act because a non-reply
23 is a reply, it says, we have no legal arguments to rebut what
24 you say. But when the Court intervened before the time
25 elapses, then it can be inferred that they could come back at

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1 some point later -- just like subject matter jurisdiction, you
2 could raise that any time.

3 But the fact is the Court did act and also you
4 acted -- by acting before they had an opportunity to reply,
5 you disadvantaged my clients because the legal issues that we
6 raised should have been considered by the Court.

7 THE COURT: Just so the record is clear, Mr. Fagan,
8 am I clear in understanding you have no objection to the fact
9 that you didn't have time to file a reply?

10 MR. FAGAN: That's correct, because our position
11 was simply very clear, that Barber was a simple matter of
12 whether or not the Pennsylvania bad faith statute was

13 preempted, that's the only thing we moved to dismiss. We set
14 forth our reasons in our motion to dismiss and supporting
15 brief, and we left it at that.

16 THE COURT: I want to state for the record that I
17 disagree with Ms. Chajkowski's statement that I acted
18 sua sponte. Sua sponte means on the Court's own initiative,
19 and I did not enter the order granting the motion to dismiss
20 on my own initiative. Rather, there was a motion filed by
21 Mr. Fagan on behalf of his client, there was a response filed
22 by Ms. Chajkowski on behalf of her client.

23 I take very seriously my obligation to be timely and
24 current with my work so that litigants don't have to wait
25 extended periods of time to have their day in court. The

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1 issue seemed to me then to be quite clear-cut, that the Court
2 of Appeals had spoken in the Barber case and it was quite a
3 clear decision for me, and that's why I granted the motion to
4 dismiss.

5 On Paragraph G -- in Paragraph G, there's a statement
6 that on February 11, 2005, Plaintiff filed a petition for
7 reconsideration and to vacate.

8 On February 15, 2005, the Court ordered Defendant to
9 respond to that motion by February 24, 2005.

10 On February 16, 2005, Defendant filed an answer and
11 denied that it is an ERISA insurer, according to what
12 Ms. Chajkowski wrote here. I think there's a dispute between

13 the parties that I remember from the last time we were
14 together in court, the Plaintiffs are insisting that the
15 Defendant denies that it is an ERISA insurer; the Defendant
16 claims -- admits that it's an ERISA insurer, but asserts that
17 the Pennsylvania bad faith statute is preempted by ERISA.

18 Do I correctly state your respective positions on
19 that?

20 MR. FAGAN: On behalf of Highmark, let us clarify
21 that in our answer we denied, as stated in the Plaintiffs'
22 complaint, that Highmark is an employee benefits plan insurer.
23 That's the way they characterized Highmark in their pleading.
24 We denied it as stated because Highmark doesn't consider
25 itself an employee benefits plan insurer.

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1 As we previously stated in our answer to Paragraph 5,
2 we admitted that Ms. Scheibler selected a health -- selected a
3 health care coverage provided by Highmark pursuant to a health
4 care contract between Plaintiff's employer and Highmark.
5 We're kind of getting into semantics here, but I don't really
6 think it matters really. It comes down to the fact that we
7 agree that this is an ERISA plan and should be covered by the
8 ERISA statute, and the Barber court says that the Pennsylvania
9 bad faith statute is preempted.

10 THE COURT: All right. The next line says --

11 MS. CHAJKOWSKI: Your Honor, before you go on, I
12 had something to say to that.

13 THE COURT: Okay, go ahead.

14 MS. CHAJKOWSKI: They did not only deny the
15 paragraph that said they were a plan insurer, they denied four
16 paragraphs that related to ERISA language. One of them said
17 that as part of their duty, it was their duty by the
18 Department of Labor regulations in the Black & Decker case to
19 inform the insured what their benefits are, what is covered,
20 what is not covered.

21 And in the case of Mr. Scheibler, they covered his
22 pre-op, post-op, hyperbaric treatments, which he had done
23 shortly after his physician made the request for coverage,
24 anticipating that the insurance would cover it. Also, in
25 their plan there are -- there was a statement in that

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1 physician's letter that if the work was not done, they were
2 jeopardizing the integrity to the jaw bone.

3 And the insurer does cover certain appliances and
4 things that would have been put into his mouth after the
5 surgery. So it was like they created a gap with the surgery
6 only.

7 They also paid for the ambulance.

8 And we learned they had certain subsidiaries that
9 they haven't disclosed, they haven't filed any disclosure
10 statements of corporate interests. And it looks like they
11 paid some of their entities in full and, you know, then they
12 are not clear about why they deny other coverages.

13 So when you say that you deny being a plan insurer,
14 but you admit the contract, Your Honor, any time a party
15 pleads their duty according to contract, they are obligated to
16 attach a copy of the contract, especially if it's 53 pages.
17 Could they explain why they haven't done that yet?

18 THE COURT: All right. The next line says that --

19 MS. CHAJKOWSKI: Your Honor, they don't have to
20 tell why they haven't attached the contract?

21 THE COURT: That's not an issue for what we're
22 focused on in this call. I'm trying to go through
23 Paragraph 11 as you requested.

24 The next paragraph says on February 23, 2005, the
25 Defendant filed a nonresponsive brief opposing

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1 reconsideration. I will state for the record that although
2 Plaintiffs believe it was nonresponsive, I didn't find it to
3 be nonresponsive, I thought it was an appropriate brief.

4 The next paragraph says that on February 23, 2005,
5 Plaintiff filed a reply to answer and affirmative defenses.

6 Next paragraph says that on February 28, 2005,
7 Plaintiff filed a reply raising Defendant's nonresponsiveness.

8 The next paragraph states that on March 1, 2005, the
9 Court ordered the parties to appear for oral argument on
10 March 10, 2005.

11 I do recall ordering that and I do recall counsel
12 appearing for oral argument. The reason I scheduled oral

13 argument was to try to be helpful to the parties, and
14 particularly to be understanding of Plaintiffs' counsel and to
15 try to explain in as genteel a way as I could that some of
16 these pleadings appeared to be unorthodox and didn't seem to
17 be entirely appropriate. But I wanted to get the parties
18 together and counsel for the parties together to try to manage
19 the way in which this case was proceeding because it appeared
20 to me that the parties were not connecting with one another.
21 So that was the reason I scheduled oral argument.

22 Two days later on March 3, 2005, Plaintiff filed for
23 an extension of time to appeal. That made no sense to the
24 Court because the case was in its infancy, there was no final
25 order entered, and it appeared to me to be, quite frankly, a

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1 frivolous pleading.

2 For that reason, on March 8, 2005, I entered a --

3 MS. CHAJKOWSKI: Your Honor, before you go, to
4 respond to the frivolous aspect. That was because if we -- if
5 the Court had granted an extension of time to appeal, I would
6 have held the Third Circuit appeal until we litigated the
7 ERISA issue because I, based on the written information that I
8 had received from the Defendant, they didn't respond to all
9 the written requests I asked for, including the first denial
10 letter, I had to get that from another source.

11 But the fact is, I don't believe there -- I believe
12 either we don't have the right Defendant or there's more than

13 one Defendant or there's some issue about the ERISA, whether
14 ERISA applies or not. If ERISA is void because of various
15 factors that aren't in place that should be in place, then an
16 extension of time to appeal would have permitted me to bring
17 bad faith back in, litigate it before the same judge in the
18 same court on the same operative facts. But when the
19 Plaintiff was denied that opportunity to have an extension to
20 appeal, there was no other choice but to appeal to the Third
21 Circuit for an en banc review.

22 Barber is a bad faith statute which is
23 quasi-criminal. The fact is it may be that the Third Circuit
24 panel erred in applying it at all to insurance because the
25 Miller case was a statute that was not bad faith at all, it

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1 had to do with the rights and duties of the parties to third
2 parties or whatever.

3 In this case you are talking bad faith. Bad faith
4 civil enforcement takes off the burden of the law enforcement
5 to enforce things like that. It gives people a remedy on a
6 preponderance of evidence standard instead of going through
7 machinations of a criminal type of thing where the standards
8 are different and the disadvantaged parties are more aggrieved
9 because it takes longer. But I just needed to enter that for
10 the record, that that was not a frivolous request.

11 THE COURT: All right. I guess everything that we
12 just heard buttresses my prior statement and I will leave it

13 at that.

14 Next entry is that on March 8, 2005, the Court
15 entered an order denying an uncontested request for extension.
16 I don't have any reason to believe that Mr. Fagan didn't file
17 any opposition to the extension of time to appeal, and I guess
18 it was my view that because that was such an unorthodox and
19 frivolous pleading, that I didn't need to wait for Mr. Fagan's
20 client to incur the time and expense to tell me that.

21 But I will give you a chance, Mr. Fagan, to speak to
22 that issue, because in Paragraph O Ms. Chajkowski seems to be
23 complaining that I didn't give you an opportunity to respond
24 to her motion for extension of time to appeal.

25 MR. FAGAN: On behalf of my client, we concur in

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1 the Court's position that the whole process seems to be a
2 little bit jumbled by unconventional filings, and that was one
3 of them, filing the extension of time to appeal. We were
4 immediately aware and concerned that it was an interlocutory
5 order, and we expected that the Court would deal with it
6 appropriately, which the Court did.

7 We didn't feel that we had to file necessarily -- and
8 take the time and effort to respond to what amounted to kind
9 of baseless motions that are really just spinning everybody's
10 wheels here. This is preventing the case from going forward,
11 which I expect that's what the Plaintiffs want to do. And if
12 they just kind of reel back a little bit and let this case

13 proceed, we can probably get it resolved or -- either through
14 settlement or through the normal court process.

15 THE COURT: All right. The next entry is that on
16 March 8, 2005, Plaintiff filed a notice of appeal. And I do
17 recall that being filed with the Court of Appeals for the
18 Third Circuit.

19 On March 10, 2005, the parties appeared before the
20 Court from 4:25 to 4:40 p.m., according to this Paragraph Q,
21 and it also says that the Court granted Plaintiffs' request to
22 amend within 30 days.

23 I do recall that oral argument when I tried as best I
24 could to explain to Plaintiffs' counsel what I have tried to
25 explain during this call to no avail. But I do recall the

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1 request was made by Plaintiffs' counsel for the opportunity to
2 amend the complaint, and I indicated at that time that I would
3 grant amendment to the complaint because leave to amend should
4 be freely granted. I also recall that it was my understanding
5 that, based upon my discussion with counsel at that oral
6 argument, that the inappropriate appeal to the Third Circuit
7 was going to be withdrawn.

8 On March 11th, 2005, the Court entered an order
9 denying the petition to vacate the order of February 1, 2005.
10 That was done for the reasons stated on the record at the oral
11 argument.

12 Then on April 8, 2005, Plaintiff filed a petition for

13 extension of time to amend. Upon receiving that extension,
14 the Court believed then and continues to believe now a few
15 weeks later that it would be a miscarriage of justice to
16 require the Defendant to spend the money and expend the time
17 necessary to respond to that. Because the case is pending
18 with the Court of Appeals for the Third Circuit, despite my
19 entreaties to Plaintiffs' counsel at the hearing that that
20 should not be the case, I decided that it would be unfair to
21 the Defendant to enter an order giving Plaintiffs an
22 open-ended extension of time to respond all the way until -- I
23 am sorry, not an open-ended time to respond, but an open-ended
24 time period to amend the complaint until the 30 days or 20
25 days after the Third Circuit rules on the appeal, I thought

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1 that would be rewarding the Plaintiff for litigation conduct
2 that seemed to me to be inappropriate. So for that reason I
3 entered the order of April 13th, 2005.

4 Then finally Plaintiffs filed this petition for
5 reconsideration. And when I received the petition for
6 reconsideration, I thought the most prudent and fair thing to
7 do for all parties involved was to schedule this conference
8 call because the pattern of unorthodox motions being filed
9 continues without abatement, and I'm doing the best I can
10 during this call to explain to both sides how I see this case.

11 And where we stand essentially is that Ms. Chajkowski
12 has made clear that she wants to pursue her appeal to the

13 Third Circuit. I am -- I've said my piece on that issue and
14 I'm not going to say any more because I don't want to in any
15 way browbeat counsel.

16 But I will state that because the case is pending
17 with the Court of Appeals, that I'm not going to entertain any
18 motions filed by either party. I'm telling both Mr. Fagan and
19 Ms. Chajkowski that I don't want to get any motions on this
20 case, I will not entertain any motions on this case during the
21 pendency of the appeal to the Third Circuit. After the Third
22 Circuit makes its decision relative to the appeal that's
23 pending, then I will be happy to revisit the issues raised in
24 this case.

25 So with that being said, I'll give Ms. Chajkowski an

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1 opportunity to say anything further that she wishes.

2 MS. CHAJKOWSKI: Your Honor, could you ask or order
3 them to send a copy of that contract that is referred to and
4 the ERISA language they rely on to establish that they are in
5 fact a party in interest here?

6 THE COURT: Again, Ms. Chajkowski, I don't think
7 you can have it both ways. If you want that contract and you
8 want other discovery from Mr. Fagan, I would be happy to order
9 it, order him to produce it if he doesn't produce it
10 voluntarily pursuant to Rule 26. But I'm only going to do
11 that if there's not an appeal pending. You've indicated
12 previously on this call that you want to pursue the appeal.

13 MS. CHAJKOWSKI: I want to finalize subject matter
14 jurisdiction.

15 THE COURT: Well, Mr. Fagan has already conceded
16 subject matter jurisdiction, and the Court believes that there
17 is subject matter jurisdiction under ERISA. So I did have
18 subject matter jurisdiction over your case until you took
19 jurisdiction away from me by sending the case to the Court of
20 Appeals.

21 Is there anything else you would like to add,
22 Ms. Chajkowski?

23 MS. CHAJKOWSKI: No, I would like to hear from the
24 Defendant.

25 THE COURT: Anything you would like to say at this

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1 time, Mr. Fagan?

2 MR. FAGAN: I think we have said enough,
3 Your Honor. I think you have tried to explain the posture of
4 the case and I think you've done a fine job of doing that, and
5 we are where we are because of Plaintiffs' actions. Once this
6 case gets back on track after the appeal, we can engage in all
7 the discovery and everything else that we need to do.

8 THE COURT: All right. Thank you, folks, have a
9 good afternoon.

10 MR. FAGAN: Thank you, Your Honor.

11 MS. CHAJKOWSKI: Thank you.

12 (Record closed).
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C E R T I F I C A T E

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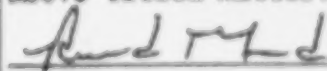
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I, Richard T. Ford, certify that the foregoing
is a correct transcript from the record of proceedings in the
above-titled matter.



Richard T. Ford

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Supreme Court, U.S.
FILED

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No. 05-

OFFICE OF THE CLERK

In The

Supreme Court of the United States

DONNA SCHEIBLER, and
WILLIAM SCHEIBLER, her husband,
Insured/Plaintiff,
Petitioner,

v.

HIGHMARK BLUE SHIELD,
Insurer, defendant,

THOMAS J. HARDIMAN,
United States District Court Judge,

Respondents.

On Petition for *Writ of Certiorari* to the
United States Court of Appeals for the Third Circuit

Appendix II – Petitioner Pleadings

Mary Ellen Chajkowski, Esquire
Petitioner's Counsel of Record
Pennsylvania ID# 86611
5510 Hobart Street
Pittsburgh, PA 15217
412-904-2222

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**IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF PENNSYLVANIA**

DONNA SCHEIBLER and
WILLIAM SCHEIBLER, her husband,

Plaintiffs,

Vs.

HIGHMARK BLUE SHIELD
Defendant.

COMPLAINT IN CIVIL ACTION

AND NOW come the Plaintiffs, Donna Scheibler and William Scheibler, her husband, by and through their attorney, Mary Ellen Chajkowski, Esquire, and file the within Complaint and represent the following in support thereof:

1. This action is brought under, and jurisdiction is vested in this Court through, the Employee Retirement Security Act (ERISA), and specifically, 29 U.S.C. § 1132(a)(1)(B), and a Pennsylvania state law claim.

2. The Plaintiff, Donna Scheibler, is an adult individual and resides at RD #2, Box 468, Greensburg, PA 15601, Westmoreland County.

3. The Plaintiff William Scheibler, husband of Donna Scheibler, is an adult individual, resides at RD #2, Box 468, Greensburg, PA 15601, Westmoreland County.

4. Plaintiff, Donna Scheibler, as an employee of ABB, Inc., is enrolled as a beneficiary of the company's health care benefits plan. William, as her husband, is entitled to the benefits of the health care plan.

5. Plaintiff, Donna Scheibler, selected the Highmark Blue Shield coverage, which is one of the health plans that ABB, Inc., offers to its employees.

6. Defendant, Highmark Blue Shield, is an employee benefits plan insurer in the State of Pennsylvania and maintains an address for its Member Grievance & Appeals Department at P O Box 535095, Pittsburgh, PA 15253-5095.

6. The Defendant, Highmark Blue Shield, does business in Pennsylvania and is headquartered at Fifth Avenue Place in Pittsburgh, PA 15222.

7. At all times relevant hereto, the Defendant, Highmark Blue Shield, provided health care insurance pursuant to an employee benefit plan on behalf of the Plaintiff, Donna Scheibler.

8. William Scheibler was diagnosed with cancer and underwent radiation treatments in 1997 after a radical neck dissection.

9. William Scheibler's treating physicians wrote letters to Defendant, Highmark, attributing William Scheibler's need for oral surgery to the extensive radiation treatments that were administered for his tonsillar carcinoma stating that the surgery is medically necessary. In a letter to the Defendant Insurer, Dr. Stephen Rendulich attributed William Scheibler's caries to *xerostomia*:

"Radiation induced caries should be treated as a late effect medical condition resulting from radiation therapy. Having hyperbaric oxygen prior to dental extractions would significantly decrease his risk of *osteoradionecrosis*, which, as you know, can be quite extensive in nature, resulting in the loss of jaw and significant dysfunction and deformity, requiring multiple operations to correct." (Exhibit A, p. 3a).

10. Defendant, Highmark, approved payment of William Scheibler's pre-op and post-op, Hyperbaric Oxygen treatments, which were done anticipating the surgery.

11. Defendant, Highmark, denied payment for the scheduled surgery.

12. After Plaintiffs received a denial for the surgical procedure; Donna Scheibler sent a letter of appeal to the Defendant, Highmark, which included letters from William Scheibler's treating physicians, relating the medical necessity for surgery to his extensive radiation treatments.

13. Defendant relied upon unspecified plan language to deny coverage.

14. Defendant, Highmark, provided a 2003 draft copy of its plan, in response to a written request from Plaintiff's counsel.

15. William Scheibler's surgery was delayed for a period of months but eventually proceeded as planned and the surgery was performed.

16. The Plaintiffs negotiated with the hospital and paid an agreed upon price for the surgery but later received statements that far exceeded the costs actually paid.

17. Plaintiffs reasonably believe that the Defendant insurer may have benefited by denying coverage to its insured, William Scheibler, for payment of his hospital costs and later accepting reimbursement in excess of the agreed upon payment actually made.

18. Plaintiff reasonably drew the conclusion in paragraph 17 because the physician cost for doing the surgery

remained the same, whether covered by insurance or paid by the Plaintiff.

19. The Plaintiffs have exhausted all of their administrative appeals.

COUNT I

Employee Retirement Income Security Act (ERISA), 29 U.S.C. s1132(a)(1)(B)

20. Plaintiffs incorporate the allegations of paragraphs 1 through 19 as if set forth here at length.

21. Under the above circumstances, the Plaintiffs are entitled to recover benefits due them under the terms of the plan, to enforce the rights under the terms of the plan, and to clarify the rights to future benefits under the terms of the plan. (ERISA), 29 U.S.C. s1132(a)(1)(B).

22. While said policy was in full force and effect, William Scheibler requested approval of benefits for his oral surgery, a procedure, which was recommended by his treating physician as medically necessary.

23. All conditions precedent under this policy have been performed by the Plaintiffs, Donna J. Scheibler and her husband, William Scheibler.

24. Defendant has failed to pay the Plaintiffs the sum of money due under the policy.

Wherefore, the Plaintiffs demand judgment against the Defendant for the reimbursement of medical care, plus interest, cost and attorney's fees, due and owing them for the wrongful denial of coverage for William Scheibler's 2004 surgical procedures.

COUNT II

Pennsylvania Bad faith Statute, 42 Pa. C.S.A. s8371.

25. Plaitiffs incorporate the allegations of paragraphs 1 through 24 as if set forth here at length.

26. The Pennsylvania Bad faith Statute, 42 Pa. C.S.A.s8371, regulates the insurance industry mandating accountability on the part of all insurance companies for any frivolous or unfoounded refusal to provide coverage in accordance with an applicable policy of insurance.

27. The Plaintiffs aver that the Defendant acted in bad faith in its actions toward them in handling the claim generally, and as set forth in the following particulars:

(A) In failing to consider all relevant factors and medical records to evaluate and determine the medical necessity of the surgery recommended by Willlliam. Scheibler's treating physicians;

(B) In failing to properly inform Mr. Scheibler of what constitutes medical necessity and why it believed his condition did not rise to that level;

(C) In failing to appreciate the success of the surgery, as evidence of the necessity of the procedure;

(D) In failing to pay for a covered benefit given the medical evidence presented.

Wherefore, the Plaintiffs request, pursuant to 42 Pa. C.S.A. s8371, an award of punitive damages, court costs and counsel fees to be paid by the Defendant, Highmark.

Respectfully Submitted,
/s/ Mary Ellen Chajkowski, Esquire

December 23, 2004

DONNA SCHEIBLER and
WILLIAM SCHEIBLER, her husband,
Plaintiff(s),

HIGHMARK BLUE SHIELD,
Defendant(s).

**PLAINTIFFS' MOTION TO DENY
DEFENDANT'S MOTION TO DISMISS**

AND NOW come the Plaintiffs, Donna Scheibler and William Scheibler, her husband, by and through their attorney, Mary Ellen Chajkowski, Esquire, hereby opposing Defendant's Motion to Dismiss Plaintiffs' Count II claim for violation of the Pennsylvania Bad Faith Statute, 42 Pa. C.S.A. Section 8371; and moves this Honorable Court to deny Defendant's Motion to Dismiss, representing the following in support thereof:

PLAINTIFF'S MATERIAL FACTS

1. Defendant referred to various paragraphs of Plaintiff's Complaint, but made no reference to Plaintiff's material factual/legal allegations

(quoted here from Complaint by paragraph #):

5. Plaintiff, Donna Scheibler, selected the Highmark Blue Shield coverage, which is one of the health plans that ABB, Inc., offers to its employees.

8. *William Scheibler was diagnosed with cancer and underwent radiation treatments in 1997 after a radical neck dissection.*

9. *William Scheibler's treating physicians wrote letters to Defendant, Highmark, attributing Wm. Scheibler's need for oral surgery to the extensive radiation treatments that were administered for his tonsillar carcinoma stating that the surgery is medically necessary. In a letter to the Defendant Insurer, Dr. Stephen Rendulich attributed William Scheibler's caries to xerostomia:*

"Radiation induced caries should be treated as a late effect medical condition resulting from radiation therapy. Having hyperbaric oxygen prior to dental extractions would significantly decrease his risk of osteoradionecrosis, which, as you know, can be quite extensive in nature, resulting in the loss of jaw and significant dysfunction and deformity, requiring multiple operations to correct." (Ex. A, p. 3a).

11. *Defendant, Highmark, denied payment for the scheduled surgery.*

12. *After Plaintiffs received a denial for the surgical procedure; Donna Scheibler sent a letter of appeal to the Defendant, Highmark, which included letters from William Scheibler's treating physicians, relating the medical necessity for surgery to his extensive radiation treatments.*

13. *Defendant relied upon unspecified plan language to deny coverage*

14. *Defendant, Highmark, provided a 2003 draft copy of its plan, in response to a written request from Plaintiff's counsel.*

15. *William Scheibler's surgery was delayed for a period of months but eventually proceeded as planned and the surgery was performed.*

18. *Plaintiff reasonably drew the conclusion in paragraph 17¹ because the physician cost for doing the surgery remained the same, whether covered by insurance or paid by the Plaintiff.*

21. *Under the above circumstances, the Plaintiffs are entitled to recover benefits due them under the terms of the plan, to enforce the rights under the terms of the plan, and to clarify the rights to future benefits under the terms of the plan. (ERISA), 29 U.S.C. 1132(a)(1)(b).*

22. *While said policy was in full force and effect, William Scheibler requested approval of benefits for his oral surgery, a procedure which was recommended by his treating physician as medically necessary.*

23. *All conditions precedent under this policy have been performed by the Plaintiffs, Donna J. Scheibler and her husband, William Scheibler.*

24. *Defendant has failed to pay the Plaintiffs the sum of money due under the policy.*

¹ 17. *Plaintiffs reasonably believe that the Defendant insurer may have benefited by denying coverage to its insured, William Scheibler, for payment of his hospital costs and later accepting reimbursement in excess of the agreed upon payment actually made.*

Wherefore, the Plaintiffs demand judgment against the Defendant for the reimbursement of medical care, plus interest, cost and attorney's fees, due and owing them for the wrongful denial of coverage for William Scheibler's 2004 surgical procedures.

2. Defendant filed a Motion to Dismiss Count II based on pre-emption.

26. *The Pennsylvania Bad faith Statute, 42 Pa. C.S.A. s 8371, regulates the insurance industry, mandating accountability on the part of all insurance companies for any frivolous or unfounded refusal to provide coverage in accordance with an applicable policy of insurance.*

3.Plaintiffs hereby Petitions this Honorable Court to Deny Defendant's Motion to Dismiss Plaintiff Count II.

I. The parties have insurance-contract privity:

A) Plaintiffs have standing;

B) This court has exclusive jurisdiction over the claims;

C) Defendant drafted the terms of Plaintiffs' insurance coverage/exclusions/costs and it issues decisions to grant or deny payment to Plaintiffs, which must be narrowly construed in favor of the Plaintiffs.

II. The Savings Claus expressly reserves regulation of insurance to state law:

A) Congress did not intend to supplant state "bad faith" insurance regulations;

B) ERISA, Department of Labor, and state "bad faith" insurance regulations share a common interest in protecting contractually defined benefits,

C) Under 42 Pa. S3871, all insureds are a protected class of persons whether the insurance contracts are under ERISA or not.

III. Public Policy Interest (state economic burden - uninsured/underinsured)

A) Defendant did not comply with ERISA regulations in shifting its burden to pay;

B) Defendant's shortfalls are supplemented by state subsidy and reimbursements.

WHEREFORE, state regulation of insurance is expressly exempt from preemption by the ERISA Savings Clause, where it *affects* the risk pooling arrangement between the insurer and insured. Kentucky Ass'n of Health Plans, Inc. v. Miller, 123 S. Ct. 1471 [30 EBC 1129] (2003). The Third Circuit noted that the United States Supreme Court in Miller articulated a two-part test which satisfies the savings clause if both prongs are met; and that Section 8371 satisfies the first, as it regulates insurers conduct by imposing industry-wide conditions on the insurance business. Barber v. Unum Life Ins. Co. of America, 383 F 3d 134 (3rd Cir. 2004) The risk pooling arrangement between insurer and insured in Barber can be materially distinguished from the risk pooling arrangement between Highmark and Plaintiffs. 42 Pa. CSA s8371 regulates and enforces an important state interest, as the state subsidizes losses of medical coverage insurers. Plaintiffs hereby petition this Honorable Court to accept all factual allegations in the Complaint and all reasonable inferences to be drawn therefrom in the light most favorable to the Plaintiffs and to deny Defendant's Motion to Dismiss Count II.

Very truly yours

January 24, 2004

/s/Mary Ellen Chajkowski, Esquire

**IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF PENNSYLVANIA**

**DONNA SCHEIBLER and
WILLIAM SCHEIBLER, her husband,
Plaintiff(s),**

v.

**HIGHMARK BLUE SHIELD,
Defendant(s).**

**PLAINTIFFS' BRIEF IN OPPOSITION TO
DEFENDANT'S MOTION TO DISMISS**

Highmark callously placed its insured in a medical and economic state of emergency by denying a reasonable request for medically necessary surgery. Highmark attempts to cap its liability to compensate Plaintiffs, within the ambit of ERISA, herein requesting Dismissal of Plaintiff's Count II claim, brought under the PA Bad Faith Statute, which neutrally regulates insurance and permits the Plaintiff to recover punitive damages.

Highmark drafted the terms of Plaintiffs' insurance coverage; including exclusions and consumer costs; and Highmark controls decisions to grant or deny coverage payment to its insured under the contract, which must be narrowly construed in favor of Plaintiffs.

Highmark calculates the risk of loss, when it assesses costs to charge an insured for coverage and Highmark losses, if any, are supplemented by state subsidy and reimbursements. Conversely, insured individuals have no say in the cost for insurance or the bundle of coverage/exclusions and no recourse but personal assets, to pay losses. The duties of insurers and rights of those insured are regulated by federal and state statute. Highmark did not

comply with ERISA regulations in shifting its burden to the protected class of persons, the insureds. The Plaintiffs, whose sons are age fifteen and seventeen, did not have reserve funds to pay for William Scheibler's surgery, which created economic chaos for the family when Highmark denied medical coverage.

JURISDICTION

Congress has divested the state courts of jurisdiction over ERISA claims. Travelers Ins. Co. v. Cuomo, 14 F. 3d 708, 714 (1993). (citing ERISA s.502(e)(1), 29 U.S.C. s 1132 (e)(1). NY State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645 (1995). This is an ERISA controversy over Highmark's denial of coverage to its insured for medically necessary oral surgery in 2004, related to his radiation treatments for cancer, which started in 1997. Plaintiff avers that Highmark denied coverage of his surgery in "bad faith" and seeks to litigate the ERISA and state claims together, to assess the extent and value of Plaintiffs' losses occasioned by Highmark's denial of contractually defined employee benefits. Uncertainty over the implications of the federal statute - s 502(e)(1) of ERISA, 29 U.S.C. s 1132(e)(1) might render the availability of a state court remedy not 'plain.' DeBuono, New York Commissioner of Health, et al v. NYSA-ILA Medical and Clinical Services Fund, U.S. Supreme Court No. 95-1594 (1997). Therefore, Plaintiffs' "Bad Faith" state claim must be litigated and construed *pari materia* with the ERISA claim, in order to render a "plain" remedy Id. within the meaning of the Act. While nothing in ERISA requires employers to establish employee benefit plans, legislative enactment of ERISA was not intended to interfere with state regulation of insurance.

COVERAGE DENIALS TO AN INSURED ARE REGULATED

The Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C.S. s1001 et seq., was enacted to promote the interests of employees and their beneficiaries in employee benefit plans, and to protect contractually defined benefits. ERISA furthers these aims, in part, by regulating the manner in which plans process benefits claims. Black & Decker Disability Plan v. Kenneth L. Nord, 123 S.Ct. 1965, 2003. ERISA empowers the Secretary of Labor to prescribe such regulations as he finds necessary or appropriate to carry out the statutory provisions securing employee benefit rights. 29 U.S.C.S s1133, 1135. Plans must provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied, setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant. 29 U.S.C.S s1133(1). ERISA further requires that plan procedures afford a reasonable opportunity for a full and fair review of dispositions adverse to the claimant. 29 U.S.C.S s1133(2). ERISA's regulatory framework presumes "good faith" that must be strictly construed, as contractually defined benefits constitute a property right relied upon in employees and their beneficiaries. Congress provided a savings clause that exempts state laws that "regulate insurance" from ERISA preemption. 29 U.S.C. s 1444(a). The third circuit held that 42 Pa. CSA s8371 regulates insurance but that it does not affect the risk pooling arrangement between insurer and insured, under materially different facts and consequences from those alleged before this court, by the Scheibler Plaintiffs.

RISK POOLING ARRANGEMENTS

Under ERISA enforcement remedies, insurers hold onto funds in dispute until judgment is rendered, at little or no additional cost. Under 42 Pa. CSA s 8371 enforcement remedies, risk pooling arrangements between parties are

affected by awarding punitive damages against bad faith insurers: “[i]n an action arising under an insurance policy, if the court finds that the insurer has acted in bad faith toward the insured...” The remedies available under s8371 are awarded or assessed against the insurer.” Id. If a Plaintiff alleges that an insurer acted in bad faith, adversely affecting the insured and the insurers’ alleged bad faith constitutes a substantial affect on the risk pooling arrangement between the parties, the claim meets the second prong of the Miller test, saving the claim from preemption. The Plaintiffs here allege that Defendant insurer denied his claim in bad faith and benefited in a way that substantially affects risk pooling, utilizing state subsidy.

In Miller, Justice Scalia considered a scenario whereby Kentucky’s Any Willing Provider Law regulates the conduct of insurance providers with regard to third-party providers. Miller 123 S.Ct. at 1477. In doing so, Justice Scalia concludes that the law “regulates insurance by imposing conditions on the right to engage in the business of insurance.” Kentucky Ass’n of Health Plans, Inc. v. Miller, 123 S. Ct. 1471 [30 EBC 1129] (2003). The Third Circuit held that 42 Pa. CSA s8371 satisfies the first prong of the Miller test as it imposes industry-wide conditions regulating insurer’s conduct in the normal operation of the business of insurance. Barber v. Unum Life Ins. Co. of America, 383 F. 3d 134 (3rd Cir. 2004). The third circuit, in Barber did not find a substantial affect to the risk pooling arrangements between the parties, to satisfy the second prong of the Miller test, where the insurer rescinded disability benefits under a group, long term disability policy, purchased by the employer. Not stated, whether disability is work related.

Labor laws hold employers responsible to compensate disabled employees for work related injuries if employer’s insurer denies coverage. Employers cannot evade liability for being uninsured/underinsured or when its insurer denies

disability coverage. However, employers are not bound by preemption from litigating bad faith insurance violations in state court. In Barber, preemption held the parties to an insurance contract where the employer is the insured and plaintiff was a beneficiary.

The savings clause is an exception protecting state laws from exemption which regulate insurance, banking and securities. Medical insurance, like securities, involves an administrator or fiduciary who has discretionary authority to determine eligibility for benefits or to construe the plans terms. The third circuit has held that "when an insurance company both funds and administers benefits, it is generally acting under a conflict that warrants a heightened form of the arbitrary and capricious standard of review." Pinto v. Reliance Standard Life Ins. Co., 214 F 3d 377, 378 (3d Cir. 2000). Plaintiff alleges that Highmark realized a benefit by denying coverage to its insured, accepting Plaintiff's reduced payment for the surgery, and accepting full state reimbursement for the services. However, the insured Scheiblers had no reserve to pay for William Scheibler's surgery. Therefore, Highmark's denial of coverage has occasioned serious losses to its insured.

The insurer/insured relationship between Scheiblers and Highmark is materially distinguished from the insurance relationship of the parties in Barber. Therefore, preemption by court dismissal, here, shifts the burden of loss from insurer to its insured, the class of persons expressly protected.

There is one set of operative facts to litigate and common identity of protected persons, which merit *pari materia* litigation and construction of the law, ERISA and Department of Labor regulations with state insurance law.

EXPRESS PREEMPTION

State regulation of insurance is expressly exempt from preemption by the ERISA Savings Clause, where it *affects* the risk pooling arrangement between the insurer and insured. Kentucky Ass'n of Health Plans, Inc. v. Miller, 123 S. Ct. 1471 [30 EBC 1129] (2003). The court must conduct a two part test pursuant to the "Miller Test", with s 8371 satisfying both prongs in order to be saved from preemption. Stone v. Disability Management Services, Inc., 31 EBC 1741 (October 14, 2003). The "Miller Test" has been applied to 42 Pa. CSA s 8371 in Stone, where the court held that the Bad Faith statute is "saved" from ERISA preemption in that the law is directed toward the insurance industry and clearly affects allocation of risk between insurer and insured in that the law provides for possibility of punitive damages. Id. Highmark, in its capacity as an insurer, is subject to Pennsylvania regulatory enforcement here. Therefore, Plaintiff's bad faith state claim must be litigated under federal jurisdiction, to assess damages in concert with ERISA, in order to render a "plain" remedy within the meaning of the state Act. DeBuono, New York Commissioner of Health, et al v. NYSA-ILA Medical and Clinical Services Fund, U.S. Supreme Court No. 95-1594 (1997). As applied here, preemption may wrongfully bar Plaintiffs' due process on the 'bad faith insurer' state claim.

CONFLICT PREEMPTION

The "any law of any State" language in the savings clause clearly indicates Congress purpose to respect state sovereignty. As applied here to Defendant, Highmark, a medical coverage insurer, Section 8371's provision of punitive damages is consistent with Congress' intent in drafting ERISA. Stone at 1748. In its footnote #3, the district court in Stone reversed its prior ruling on the issue of conflict preemption: In making this determination, we acknowledge that this Court had previously determined that Section 8371 was subject to conflict preemption. However, in light of

Miller and the persuasive reasoning put forth by Judge Newcomer in Rosenbaum, we exercise our judicial discretion to reconsider this issue. Stone at 1748.

CONCLUSION

Highmark did not process Plaintiffs' claim for benefits according to the Department of Labor regulations. Congress did not intend ERISA to preempt state laws which regulate and sanction insurers who realize an economic benefit from wrongful denial of coverage. If Plaintiffs allegations are accepted as true and all reasonable inferences drawn therein: 1) Highmark did not provide Plaintiffs adequate notice in writing, setting forth the specific reasons for its denial in a manner calculated to be understood by the participant. 2) Highmark provided Plaintiffs no opportunity for full and fair review of its adverse decision, short of filing a Complaint in federal court. And, 3) Highmark realized an economic benefit by seeking full reimbursement for Plaintiffs surgery. Highmark's failure to adhere to ERISA regulations combined with the prospect that Highmark realized an economic benefit from its decision to wrongfully deny coverage to its insured raises a material question of fact. There is legal authority that Section 8371 is saved from preemption. Plaintiff's cause of action can be distinguished from Barber v. Unum, based on differences of material fact concerning allocation of losses.

WHEREAS, Plaintiff, William Scheibler's medical condition requires ERISA civil enforcement in the immediate future and delay burdens the entire family. Plaintiff respectfully petitions this honorable court to issue an order denying Defendant's Motion to Dismiss Plaintiffs' Count II 'bad faith insurer' state claim.

January 28, 2004

Respectfully submitted,

Mary Ellen Chajkowski, Esq.

**IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF PENNSYLVANIA**

**DONNA SCHEIBLER and
WILLIAM SCHEIBLER, her husband,
Plaintiff(s),**

v.

**HIGHMARK BLUE SHIELD,
Defendant(s).**

Plaintiffs' Petition for Reconsideration

AND NOW, come the Plaintiffs, Donna Scheibler and William Scheibler, her husband, by and through their attorney, Mary Ellen Chajkowski, Esquire, to hereby Petition the district court to Reconsider its February 1, 2005 *Memorandum Opinion and Order* granting Defendant's Motion to Dismiss the Plaintiffs' Complaint, with prejudice. Plaintiffs aver the following, in support of the court's Reconsideration:

1. The district court's dismissal of Count II, with prejudice, cut off the Plaintiff's right to a full and fair review of defendant's denial of medical insurance coverage.
2. Whether the Plaintiffs' Highmark medical insurance is part of a qualified plan is a material question of fact, precluding dismissal of Plaintiff's bad faith insurance claim, where coverage and exclusions are not specific.

3. In response to a written request for a copy of the plan, Highmark sent a copy of an August 2003 "draft" that was never approved (R.1a, 12a).
4. Highmark's letter dated May 17, 2004 (Exhibit A) cited its medical policy D-6 as its basis for denial yet sent its medical policy D-5 (R.1a, 10a, 11a) a collateral document (November 2003) to the plan "draft" (R.13a).
5. Highmark's letter (Ex.A), stating that an Appeals Committee reviewed Plaintiff's request for reimbursement, is not supported by its Outsource Report (R.7a, 8a, 9a) on 4/21/04 – "use denial letter W1-M" (R.9a); and (R.8a) "Please complete review by 5/14, and do not send letter. Thanks." The 05/14/04 Physician reviewer Report is unsigned and refers to #D-6.
6. Highmark's reviewer misspelled/questioned "(?osteonecrosis)" (R.9a), a basic medical term *osteoradionecrosis* (Exhibit B) that distinguishes bone death caused by radiation injury from infection of compromised bone.
7. William Scheibler's treating physicians attributed his bone loss and the medical need for surgery to his radiation treatments (R.3a, 4a,5a,6a).
8. The district court failed to incorporate plaintiffs' legal arguments distinguishing the Third Circuit application of law in Barber v. Unum Life Ins. Co. of America, 383 F.3d 134 (3d Cir. 2004) from the proposed application of law to the facts *sub judice*, including the materially different risk pooling arrangement between insurer and insured.

9. Whether her addressed a group, long-term disability insurance policy, purchased by the employer, a contract with specific coverage/exclusion language.
10. Whether the Highmark "draft" plan controls; and whether the "draft" plan offered procedures that afford a reasonable opportunity for a full and fair review of dispositions adverse to claimants 29 U.S.C.S. s1132(2) is a material question of fact, that precludes dismissal with prejudice.

WHEREFORE, Plaintiffs allege facts to support a finding that two material issues of fact preclude dismissal with prejudice:

- 1) Whether the "draft" plan is qualified; and

If it is qualified,

- 2) Whether the plan offers procedures that afford a reasonable opportunity for full and fair review of dispositions adverse to claimants.

And Plaintiffs Petition the district court to Reconsider and Vacate its February 1, 2005 Order that Plaintiffs' Count II be dismissed with prejudice.

Respectfully submitted,

/s/Mary Ellen Chajkowski, Esq.
Attorney for Plaintiffs

February 10, 2005

**IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF PENNSYLVANIA**

DONNA SCHEIBLER and
WILLIAM SCHEIBLER, her husband,
Plaintiff(s),

v.

HIGHMARK BLUE SHIELD,
Defendant(s).

**PLAINTIFFS' REPLY TO DEFENDANT'S
ANSWER AND AFFIRMATIVE DEFENSES**

AND NOW come the Plaintiffs, Donna Scheibler and William Scheibler, her husband, by and through their attorney, Mary Ellen Chajkowski, Esquire, to hereby Reply to Defendant, Highmark, Answers to Plaintiffs' Complaint. Highmark Answers raise material fact questions (MFQ), which preclude dismissal:

Highmark lists as its "**First Defense**" - Answer to Plaintiffs' Complaint:

1. Object. MFQ: Whether Highmark is denying Plaintiffs' ERISA claim in addition to its first motion to deny Plaintiffs' state law claim?

5. Object. Plaintiffs' are not privy to any contract between Highmark and the employer and Highmark did not attach a copy of the contract referred to in its Answer.

6. Object. MFQ: On what basis does Highmark deny Plaintiffs' allegation that Highmark is an employee benefits plan insurer?

7. Object. MFQ: Highmark's denial is contradicted by its May 17, 2004 letter to Plaintiff (Petition for Reconsideration), which states Plaintiffs' ERISA rights.

8. Object. Highmark insured and paid for William Scheibler's 1997 and subsequent treatments and, as such, has access to those payment records, which needed to be fully considered with William Scheibler's medical letters of appeal.

9. Object.

10. Object.

11. Object.

13. Object. MFQ: Highmark referred to D-6 plan language and provided the D-5 language, when requested by counsel, a collateral document to the plan booklet.

14. Object. The letter from Plaintiffs' Counsel was sent to Highmark on June 1, 2004 (Exhibit A) and acknowledged by Highmark on June 9, 2004 (Exhibit B). MFQ: Whether laches and statute of limitations are "good faith" affirmative defenses proffered by Highmark?

15. Object. MFQ: Whether Highmark accepted reimbursement for the same?

16. Object. Upon Reconsideration of Dismissal, this fact, and all reasonable inferences, must be construed in favor of the Plaintiffs.

17. Object. Upon Reconsideration of Dismissal, this fact, and all reasonable inferences, must be construed in favor of the Plaintiffs.

18. Object. Upon Reconsideration of Dismissal, this fact, and all reasonable inferences, must be construed in favor of the Plaintiffs.

Count I
ERISA

21. Object. MFQ: Whether Highmark is permitted to deny that express ERISA language applies to Plaintiffs' ERISA Claim when Highmark's May 17, 2004 letter of denial informs Plaintiffs of their right to appeal it under ERISA?

23. Object.

24. Object. Plaintiffs demand an offer of proof.

Count II

PA Bad Faith Statute, 42 Pa. C.S. s8371

26. Object. MFQ: Whether Highmark Answers denying ERISA liability make Highmark subject to the insurance Bad Faith Statute in federal court, as the ERISA claim must first be considered under exclusive federal jurisdiction?

27. Object. Non-responsive Answer.

Second Defense

28. Object as disputed. Upon Reconsideration of Dismissal, this fact, and all reasonable inferences, must be construed in favor of the Plaintiffs.

Third Defense

29. Object as disputed. Upon Reconsideration of Dismissal, this fact, and all reasonable inferences, must be construed in favor of the Plaintiffs.

Fourth Defense

30. Object as disputed. Upon Reconsideration of Dismissal, this fact, and all reasonable inferences, must be construed in favor of the Plaintiffs.

Fifth Defense

31. Object as disputed. [See Plaintiff's Petition for Reconsideration for explanation for documents presented in the Complaint.] Upon Reconsideration of Dismissal, these facts, and all reasonable inferences, must be construed in favor of Plaintiffs, Donna Scheibler and William Scheibler.

"Ninth" Defense

32. Object as disputed. Upon Reconsideration of Dismissal, this fact, and all reasonable inferences, must be construed in favor of the Plaintiffs.

Tenth Defense

33. Object as disputed. Upon Reconsideration of Dismissal, this fact, and all reasonable inferences, must be construed in favor of the Plaintiffs.

Eleventh Defense

34. Object, as affirmative defenses not raised in Highmark's first pleading were waived procedurally. If not waived, the laches affirmative defense has no factual basis.

Twelfth Defense

35. Object, as affirmative defenses not raised in Highmark's first pleading were waived procedurally. If not waived, the statute of limitations defense is not supported by factual basis nor legal authority.

MFQ: Whether laches and statute of limitations are good faith affirmative defenses where Plaintiffs' Petition for Reconsideration raises Defendant Highmark's inadequate appeal procedure as a material fact question?

WHEREFORE, Plaintiffs, Donna Scheibler and William Scheibler, submit this Reply to Defendant's Answers to the Complaint and again Petition the district court to Reconsider and Vacate its February 1, 2005 dismissal with prejudice.

WHEREAS, Plaintiffs petition this honorable court to enter an order on the Petition for Reconsideration prior to Plaintiffs' thirty (30) day deadline to submit a Notice of Appeal. All of Plaintiffs' factual allegations, and reasonable inferences that may be drawn from them, including any responses or lack thereof, must be construed in favor of the Plaintiffs, Donna Scheibler and William Scheibler.

Respectfully submitted,

/s/ Mary Ellen Chajkowski, Esquire

**IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF PENNSYLVANIA**

**DONNA SCHEIBLER and
WILLIAM SCHEIBLER, her husband,
Plaintiff(s),**

v.

**HIGHMARK BLUE SHIELD ,
Defendant(s).**

**PLAINTIFFS' REPLY TO DEFENDANT'S
BRIEF IN OPPOSITION TO
PLAINTIFFS' PETITION FOR RECONSIDERATION**

AND NOW come the Plaintiffs, Donna Scheibler and William Scheibler, her husband, by and through their attorney, Mary Ellen Chajkowski, Esquire, to hereby Reply to Defendant, Highmark's Brief in Opposition to Plaintiffs' Petition for Reconsideration:

1. Plaintiffs ask the district court to fully consider the fact that Defendant chose not to respond to every fact in the Petition for Reconsideration, which must be construed in favor of Plaintiffs.

2. ERISA regulations were not adhered to by Defendant, therefore Highmark does not seek the protective ambit of ERISA as a clean hands insurer.

3. Substantively, absent an adequate appeal procedure that is understood by the participants, Plaintiffs' only recourse for due process in claims against the Defendant is with the courts and federal courts have a constitutional role in ERISA enforcement.

4. There is one operative set of facts between Plaintiffs' claims, which makes them pendant claims that must be litigated together.

5. Congress reserved exclusive jurisdiction of ERISA with the federal court, which necessitates that both claims be tried together in federal court.

6. There is no automatic ERISA pre-emption for claims regarding insurance, banking and securities, pursuant to the savings clause.

7. There are factual allegations and legal arguments raised by the Plaintiffs' to warrant jurisdiction based on the risk allocation prong of Miller that were not present in the third circuit consideration of Barber, which Defendant did not address in its brief. Nor did Defendant address risk allocation in any other pleading.

8. Plaintiffs, as insureds, are members of the ERISA protected class.

9. Defendant admits that this court's February 1, 2005 dismissal is vague. See Highmark's Brief, page 2, footnote 1, which states:

"Highmark is unclear how these allegations are implicated by the court's dismissal of Count II based upon ERISA pre-emption doctrines, and how they might be considered in order to effect a reconsideration of the Court's decision."

10. Plaintiffs constitutional right to due process takes legal precedence over pre-emption "doctrines" and Plaintiffs are prejudiced by this dismissal.

WHEREFORE, Plaintiffs, Donna Scheibler and William Scheibler, submit this Reply to Defendant's Brief in Opposition to Plaintiffs' Petition for Reconsideration; and again Petition the district court to Reconsider and Vacate its dismissal with prejudice.

WHEREAS, Plaintiffs petition this honorable court to enter an order on the Petition for Reconsideration prior to Plaintiffs' thirty (30) day deadline to submit a Notice of Appeal.

WHEREFORE, All of Plaintiffs' factual allegations, and reasonable inferences that may be drawn from them, including any responses or lack thereof, must be construed in favor of the Plaintiffs, Donna Scheibler and William Scheibler.

Respectfully submitted,

February 23, 2005

Mary Ellen Chajkowski
Attorney for the Plaintiffs

**IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF PENNSYLVANIA**

**DONNA SCHEIBLER and
WILLIAM SCHEIBLER, her husband,
Plaintiffs,**

v.

**HIGHMARK BLUE SHIELD,
Defendant(s).**

PETITION FOR EXTENSION OF TIME TO APPEAL

AND NOW, come the Plaintiffs, by and through their attorney, Mary Ellen Chajkowski, Esquire to Petition this honorable court for Permission To Appeal the February 1, 2005 Order of the district court, entered on February 2, 2005, granting Defendants' Motion to Dismiss Count II of Plaintiffs' Complaint, with prejudice. Plaintiffs aver the following in support of this Petition:

1. Defendant Highmark's medical insurance was selected as one of several plans offered by Plaintiff Donna Scheibler's employer.

2. Plaintiffs filed a Complaint to appeal Defendant's denial of medical coverage, Count I an ERISA violation and Count II a Bad Faith Insurance Claim, pendent claims with one set of operative facts which must be tried together, as Congress has reserved exclusive federal jurisdiction over ERISA claims.

3. Defendants attempt to avoid punitive damages based on ERISA; while Defendants' Answer to Appellants' Complaint disputes Defendants' ERISA liability in Defendants' Answers to Complaint paragraphs # 1, 6, 7, and 21.

4. Defendants Motion to Dismiss Count II created an ambiguity as Count I may be interlocutory, despite Defendants express intent to deny ERISA liability.

5. Plaintiffs petition this honorable court for an Extension of Time to Appeal the district court's dismissal of Count II in order in to preserve their appellate rights.

WHEREAS, Plaintiffs have shown cause to request an Extension of Time to Appeal and request the court's full consideration of this Petition.

Respectfully submitted,

Mary Ellen Chajkowski, Esquire

**IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF PENNSYLVANIA**

DONNA SCHEIBLER and
WILLIAM SCHEIBLER, her husband,

Plaintiff(s),

v.

HIGHMARK BLUE SHIELD,

Defendant(s).

**SUGGESTION OF DEATH UPON THE RECORD
Under Rule 25 (a)**

AND NOW comes Plaintiff Donna Scheibler, by and through her attorney Mary Ellen Chajkowski, Esquire, to suggest upon the record, pursuant to Rule 25(a), the death of Plaintiff William Scheibler, her husband, during the pendency of this action.

This action shall proceed in favor of Donna Scheibler and against Highmark.

Respectfully submitted,

/s/Mary Ellen Chajkowski

**IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF PENNSYLVANIA**

DONNA SCHEIBLER and
WILLIAM SCHEIBLER, her husband,
Plaintiff(s),

v.

HIGHMARK BLUE SHIELD,
Defendant(s).

Petition for An Extension of Time to Amend Complaint

AND NOW, come the Plaintiffs, by and through their attorney, Mary Ellen Chajkowski, Esquire, to Petition this honorable court to grant their request for an extension of time to amend the Complaint:

1. Defendant filed a Motion to Dismiss Count II, Plaintiffs' claim for punitive damages occasioned by Defendant's Bad Faith denial of medical insurance coverage, pursuant to state law 42 Pa. C.S. s8371, which the district court granted.

2. Plaintiff requested permission to amend the complaint on March 10, 2005, which the court granted.

3. Plaintiff filed a notice of appeal before the Third Circuit on the dismissal, which is pending *en banc* consideration; therefore, Plaintiff hereby requests a reasonable extension of time to amend the Complaint.

WHEREAS, Plaintiff requests a reasonable extension of time to amend the Complaint, requesting thirty days after the pending appeal is concluded.

Respectfully submitted,
Mary Ellen Chajkowski, Esquire

**IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF PENNSYLVANIA**

**DONNA SCHEIBLER and
WILLIAM SCHEIBLER, her husband,
Plaintiff(s),**

**v.
HIGHMARK BLUE SHIELD,
Defendant(s).**

**PLAINTIFFS' PETITION FOR RECONSIDERATION
Of the April 13, 2005 Court Order
Denying Plaintiff's Petition to Amend Complaint**

AND NOW come the Plaintiffs, by and through their attorney, Mary Ellen Chajkowski, Esquire, to hereby Petition for Reconsideration of the April 13, 2005 district court order denying Plaintiffs' petition for an extension of time to Amend:

The Parties

For more than twelve years, Plaintiffs have been Blue Cross /Blue Shield (BC/BS) insureds, through Keystone and/or Defendant Highmark, which have merged. The family was insured through William Scheibler's ABB employment until disability; which he continued for two years. During that time, plaintiffs were insured by two BC/BS policies; through William's ABB employer and Donna's Sony employer. When Donna accepted employment with ABB, she selected Highmark at a premium cost in order to maintain continuous BC/BS medical coverage for her family. Plaintiffs have two sons, age fifteen and seventeen. Plaintiff Donna Scheibler is an ABB factory employee, the position William held prior to his disability.

January 2004, Plaintiff William Scheibler was cancer free for more than five years. Though disfigured by neck surgery, William participated in everyday life; he drove to church, his sons games and school functions.

January 19, 2004 (Exhibit A), William's physician wrote a letter requesting preauthorization for medically necessary oral surgery, including pre-op and post-op hyperbaric treatments to assist healing, which Defendant acknowledges receiving (R.).

As months passed, William's teeth started to fall out one by one; pain and depression increased, causing him to withdraw. Plaintiff Donna Scheibler worked full time and raised two sons during the years that her husband battled various health problems but experienced a great deal of duress over Highmark's failure to acknowledge the medical advice of treating physicians (R. 2a). These events created stress among family members, for which they sought therapy. William was prescribed medication, for pain and depression, and experienced dramatic weight loss as mouth pain made it difficult to eat

While awaiting an insurance decision, the parties learned that William's mother was diagnosed with cancer, creating more duress, as it followed the recent death of his father. William was frustrated by Defendant's delay and lack of communication. William made calls to Defendant (Exhibit E) and wrote letters to elected congressional representatives (Exhibits B, C, D). Defendant's material representations to the written inquiry of the congressional representatives are not supported by record evidence.

Plaintiffs refinanced their home to pay for surgery and related expenses pending appeals to Defendant. Although the parties originally had mortgage insurance, they did not qualify in 2004 based on William's medical condition. The plaintiffs (age 45) were placed in a position,

for the first time in their lives, to accept help from their church.

Defendant, Highmark, whose merger with Pennsylvania's Blue Cross/Blue Shield created an entity with 2.8 million subscribers. Defendant Highmark accepts state subsidy. In 2004, Defendant Highmark reported the following information to the public:

2004 Highmark reported that it held over two billion dollars in reserve,

2004 Highmark reported over 300 million dollars in profit, and

2004 Highmark reported one billion dollars in revenue to its dental subsidiary.

Defendant Highmark did not Answer the Complaint within 20 days as ordered, when accepting service. Highmark filed no corporate disclosure with the district court and an incomplete corporate disclosure with the appeal court. Highmark's May 17, 2004 (R. 34b) and May 21, 2004 (Exhibit E) letters contain no return address and direct Plaintiffs to the same 800 phone number to make inquiries. In its pleadings, Highmark admits certain payments of pre-op and post-op treatments but deny making the decision denying coverage for surgery, without identifying what entity makes coverage decisions.

Correspondence to Plaintiffs contained double entity names on the letterhead: Highmark Blue Cross/Blue Shield and Keystone Health Plan West A Highmark Company. [Again no return address and forwarding further inquiry to a different 800 phone number].

Referencing that information with information provided to Plaintiffs Congressional representatives and the Defendant's vague and sometimes contradictory responses in the pleadings, the issue of "standing" is ambiguous.

March 3, 2005 the parties were Ordered to Appear for Oral Argument re: Petition for Reconsideration (R. 72b). March 10, 2005 statements by the district court (R. 92b) were Plaintiffs' first Notice that its due process on Defendant's conflicting responses in the pleadings were no longer at issue and Plaintiffs' counsel requested permission to amend the Complaint, which the court granted. April 8, 2005, Plaintiff filed a Petition for an Extension of Time to Amend, which the district court denied.

The Plaintiffs aver the following to support the district court's Reconsideration:

1. Plaintiff was first notified that Defendant intended to change its position that it is NOT an ERISA insurer on March 10, 2005 (R. 93b), when the parties appeared before the court, as Ordered, for "Oral Argument re: Motion for Reconsideration (R. 72b).
2. The March 10, 2005 statements by the district court, about its application of due process and material facts (R. 94b); and its *sua sponte* acceptance of Highmark's status as an ERISA Defendant (R. 93b), are presently under appeal pursuant to Plaintiff's Petition for *en banc* consideration. Due process cannot be waived by courts on any level.
3. Plaintiff's substantive right to due process; barred by Defendant's failure to adhere to ERISA Department of Labor Regulations (R. 21b - Black & Decker) and the district court's application of the Barber case to the facts alleged *sub judice*, will create a constitutional conflict in federal circuit courts, if upheld.

"Although in general federal courts must give the same effect to state court judgment that

would be given by court of state in which judgment was rendered, an exception exists for state court rulings made in absence of . . . due process, in which case federal court may declare state court's judgment void ab initio and refuse to give it effect in federal proceeding."

Twin City Fire Insurance Co. v. Adkins, 2005 WL 486670 (6th Cir. 2005).

The Sixth Circuit in Adkins went on to cite World-Wide Volkswagen Corp. v. Woodson, 444 U.S. 286 (U.S. 1980), where it held that "a judgment rendered in violation of due process is void in the rendering State and is not entitled to full faith and credit elsewhere." Woodson at 291, quoted in Adkins, 2005 WL 486670 at 5. For the district court to not grant a reasonable extension to Amend appears to violate due process.

4. The district court must fully consider the fact that Defendant chose not to respond to material allegations, which must be construed in favor of Plaintiffs.

5. ERISA notice and appeal regulations were not adhered to by Defendant. Absent "plan" due process that is understood by the participants, Plaintiffs' due process on denial of their medical insurance claim, and the harms it occasioned, is with the courts.

6. The savings clause exception to ERISA pre-emption, for claims regarding insurance, banking and securities, must be strictly construed in favor of insureds, where the district court acknowledges plaintiff's allegation that an insurer defendant may have realized an economic gain at the insured's expense (R.27b).

7. The district court's February 1, 2005 order (R. 29b) acknowledged Plaintiffs' Response in Opposition and Motion to Deny - Defendant's Motion to Dismiss, filed January 28, 2005, that included factual allegations and legal argument Defendant is a fiduciary decision making insurer as described in Pinto v. Reliance Standard Life Ins. Co., 214 F. 3d 377,378 (3d Cir. 2000), where the third circuit held that "when an insurance company both funds and administers benefits, it is generally acting under a conflict that warrants a heightened form of the arbitrary and capricious standard of review. Id. The Pinto standard of review is more stringent that applied by a panel of the appellate court in Barber. However, Plaintiffs' legal arguments were not incorporated in its Opinion (R. 26b), which the district court entered before Defendant's ten-day Response period (R. 13b) had elapsed.

8. Defendant Highmark, in its Answer and Affirmative Defenses, identifies itself as an insurer in contract with employer (R. 44b, #5), but fails to attach a copy of said contract and Defendant denies that it is a benefits plan insurer (R. 45b, #6).

9. If Defendant's contract were an arms length transaction and Defendant intended to evade liability to Plaintiffs, it has a legal right to join an additional defendant, which Highmark did not do.

10. Defendant admitted receipt of a January 19, 2004 letter (Exhibit A) from Plaintiff's physician, Dr. Rendulich, DDS, requesting authorization for payment of pre-op and post-op treatments and the cost of medically necessary surgery (R. 45b, # 9); admits approving payment for hyperbaric oxygen treatments (R. 45b, #10); but filed a non-responsive and confusing Answer to plaintiffs' Complaint allegation #11, that "Defendant Highmark denied payment for the scheduled surgery".

11. Plaintiffs' cause of action has been inequitably handicapped and prejudiced by a series of material sua sponte court actions and omissions; including, *inter alia*, the following:

A) 12/23/04 Complaint filed; no enforcement of Rule 26 disclosures to date.

B) 01/03/05 Defendant accepted service, ordered to Answer within 20 days.

C) 01/13/05 Defendant filed a Motion to Dismiss by ERISA Preemption.

D) 01/14/05 district court Ordered the parties to submit to its Motions rules.

E) 01/28/05 Plaintiffs filed Opposition in Response and Motion to Deny.

F) 02/01/05 district court granted Dismissal before response time lapsed.

G) 02/11/05 Plaintiff filed Petition for Reconsideration and to Vacate.

H) 02/15/05 district court Ordered Defendant to respond by 02/24/05.

I) 02/16/05 Defendant filed Answer and denied that it is an ERISA insurer.

J) 02/23/05 Defendant filed non-responsive Brief Opposing Reconsideration.

K) 02/23/05 Plaintiff filed Reply to Answer and Affirmative Defenses.

L) 02/28/05 Plaintiff filed Reply raising Defendant's non-responsiveness.

M) 03/01/05 court Ordered the parties to appear for Oral Argument 03/10/05.

N) 03/03/05 Plaintiff filed for an Extension of time to Appeal.

O) 3/08/05 court entered Order denying uncontested request for extension.

P) 03/08/05 Plaintiff filed a Notice of Appeal.

Q) 03/10/05 The parties appeared before the court 4:25 to 4:40 pm (R. 84b).

R) The court granted Plaintiff's request to Amend within 30 days.

S) 03/11/05 court entered Order denying Petition to Vacate 02/01/05 Order.

T) 04/08/05 Plaintiff filed Petition for Extension of Time to Amend.

U) 04/13/05 court entered Order denying uncontested request for extension.

The district court inequitably denied uncontested motions (O, U) and expanded Defendant's response period (F, H, M), pursuant to its order (D). The record, including failure to enforce rule 26, creates an inference that Defendant lacks "standing" to litigate.

12. Defendant denied Complaint allegation #13, that "Defendant relied upon unspecified plan language to deny coverage" without clarification to support two pages improperly referenced (R. 10a-11a) in its May 14, 2004 letter to Plaintiff.

13. Highmark's unsigned letter (Exhibit G) denies coverage for "Office Surgical" extractions, which may not be eligible for state subsidy, a material fact which explains Highmark's failure to respond to Plaintiffs' allegation that Defendant profited.

14. Record pleadings and the transcript (R.87b-89b) created material questions of fact, precluding Dismissal (R. 57b-62b; R. 67b-69b), which the district court did not incorporate in its Order March 10, 2005 (R. 83b).

15. The record pleadings reflect ambiguity about Defendant's "standing" in this litigation; a material jurisdictional issue that can be raised at any time.

16. Defendant materially misrepresented the effective date of coverage and its appeal process (Exhibit F in written statements made to Plaintiff's elected congressional representatives, who made written inquiries on Plaintiff's behalf (Exhibits B, C, D).

17. Defendant's non-responsive Answer to paragraph 14 of the Complaint is refuted by a copy of Plaintiff's June 1, 2004 letter (R. 63b), acknowledged by its reply (R. 64b).

18. Defendant's request, from Plaintiffs' Counsel, for a "HIPPA compliance" authorization did not yield a single medical record (R. 1a-84a), which indicates that Defendant insurer never considered Plaintiffs medical records in its decision to deny coverage of Plaintiff's medically necessary surgery in January 2004.

19. No medical records were incorporated by Defendant's Expert (R. 7a).

WHEREFORE, All of Plaintiffs' factual allegations, and reasonable inferences that may be drawn from them, including any responses or lack thereof, must be construed in favor of the Plaintiffs, Donna Scheibler and William Scheibler.

WHEREAS, the record, including failure to enforce rule 26, creates an inference that Defendant lacks "standing" to litigate. Plaintiffs reasonably request that the district court 1) permit Defendant to respond to the allegations in this Petition; 2) that it Order Defendant to produce a copy of the contract with Plaintiffs' employer referred to in its pleading (R. 45b); 3) that it equitably enforce FRCP 26, so that Plaintiff may identify the correct parties and causes of action; and that 4) it grant a Plaintiff a reasonable extension of time to produce a deposition of Defendant's reviewing

committee, including its expert, Dr. John Boggiano, Oral and Maxillary Surgeon (R. 1a), and 5) to grant an Extension of Time to Amend the Complaint.

Respectfully submitted,

April 22, 2005

/s/Mary Ellen Chajkowski, Esquire
Attorney for the Plaintiffs

**IN THE UNITED STATES COURT OF APPEALS
FOR THE THIRD CIRCUIT**

Nos. 05-1717 & 05-2527

DONNA SCHEIBLER and :
WILLIAM SCHEIBLER, her husband, :
Appellant(s),

v.

HIGHMARK BLUE SHIELD,
Respondent(s).

**APPELLANTS' JURISDICTIONAL STATEMENT
MOTION FOR INTERLOCUTORY APPEAL**

AND NOW, come the Appellants, by and through their attorney, Mary Ellen Chajkowski, Esquire to file this Jurisdictional Statement, as the federal law applies to the facts at issue before this Appellate Court, and to move this court for interlocutory appeal:

1. Appellants, as "plan insured" members of the protected class of persons, within the express language of ERISA and Pennsylvania's bad faith insurance regulatory statute at 42 Pa. C.S. Section 8371, filed a Complaint which alleged that Appellee Insurer's denial of coverage constituted a violation of the federal and state statutes and Appellant's substantive right to due process, which requires *strict scrutiny* appellate review.

2. Appellant Donna Scheibler chose Appellee's insurance coverage, from several health plans offered by her employer, and Appellant pays part of the cost for coverage.

3. Appellee, a state subsidized Blue Shield insurer, provided coverage to William Scheibler through his employment for more than ten years and prior to disability.

4. Medical insurance, like securities, involves an administrator or fiduciary who has discretionary authority to determine eligibility for benefits or to construe the plans terms. This Appeal Court has held that “when an insurance company both funds and administers benefits, it is generally acting under a conflict that warrants a heightened form of the arbitrary and capricious standard of review.” Pinto v. Reliance Standard Life Ins. Co., 214 F 3d 377, 378 (3d Cir. 2000).

5. Appellee did not deny Appellant’s Complaint allegation that Appellee realized a benefit denying coverage to its insured, accepting Plaintiff’s reduced payment for the surgery, and accepting state reimbursement for the services.

6. Appellant herein seeks *en banc* appellate review of its panel decision preempting Pennsylvania’s bad faith law at 42 Pa. C.S. Sec. 8371, in Barber v. Unum Life, 383 F.3d 134 (3d Cir. 2004), which may have erred in extending preemption of a dissimilar state law in Kentucky Ass’n of Health Plans, Inc. v. Miller, 123 S. Ct. 1471 [30 EBC 1129] (2003) to Pennsylvania’s bad faith insurance law.

7. Barber v. Unum Life, 383 F.3d 134 (3d Cir. 2004) an interlocutory appeal under 28 U.S.C. section 1292(b), decided by a panel of this appellate court, inequitably and adversely preempts “plan insureds” only from civil enforcement of the “bad faith” law.

8. The appeals before this court are of great public importance to all third circuit healthcare coverage “plan insureds”; “plan administrators”; and healthcare providers, which merits *en banc* appellate review.

9. Appellants' substantive right to due process warrants this appellate court's exercise of *en banc* jurisdiction to hear an interlocutory appeal, under 28 U.S.C. section 1292(b), as a recent decision by a panel of the Third Circuit may bind district courts to preempt a neutral state law intended to regulate and sanction an insurer's "bad faith" failure to process insurance claims Barber v. Unum Life, 383 F.3d 134 (3d Cir. 2004).

10. Appellant's federal protection here includes the Department of Labor Regulations, requiring notice, specificity in denial, and a written appeal procedure, in order to qualify Appellee to first establish "ERISA standing" before filing its motion to dismiss Appellant's "bad faith" insurance claim which did not happen here.

11. A federal appeals court, in Twin City Fire Insurance Co. v. Adkins, 2005 WL 486670 (6th Cir. 2005), cited World-Wide Volkswagen Corp. v. Woodson, 444 U.S. 286 (U.S. 1980), where it held that "a judgment rendered in violation of due process is void in the rendering State and is not entitled to full faith and credit elsewhere." Woodson 291.

12. Appellant's right to due process takes precedence over requirements that an Order be certified, within the meaning of 28 U.S.C. 1291; and warrants an interlocutory appeal, under 28 U.S.C. 1292(b), as a panel of this appeal court did in Barber.

13. Appellant's appeal under 05-1717 petitions the district court to note the ambiguity regarding Appellee's standing, and the court's jurisdiction, where Appellee:

A) Filed a motion for dismissal based on ERISA preemption;

B) Then denied being an ERISA insurer in its Answer filed after dismissal;

C) Admitted making certain payments on behalf of its insured but denied that it made the decisions in refusing certain other payments, including surgery.

14. The ambiguity surrounding Appellee's standing and the court's subject matter jurisdiction were created by the failure to enforce Rule 26 prior to dismissal.

15. Appellant's appeal under 05-2527 is a collateral order, denying Appellant's petition to extend its March 10, 2005 approval to Amend, pending this court's decision on Appellant's 05-1717 appeal of the district court's dismissal of the bad faith claim.

16. The Pennsylvania rules of Appellate Procedure would permit Appellants' appeals:

A) Pursuant to Pa. R.A.P. 312, permit an interlocutory appeal by permission; B) Collateral Orders, pursuant to Pa. R.A.P. 313(a), are permitted;

C) Collateral is defined in 313(b) ...where the right involved is too important to be denied review and the question presented is such that if review is postponed until final judgment in the case, the claim will be irreparably lost.

17. Preemption of the state "bad faith" statute effectively denies Appellant the right to recover punitive damages, an inequitable application of law where similarly situated insureds, if not participating in a "plan", are not preempted by ERISA.

18. Pursuant to federal rule of procedure 54(b), Judgment upon multiple claims,

"When more than one claim for relief is presented in an action, ...the court **may** direct the entry of a final

judgment as to one or more but fewer than all the claims only upon an express direction for the entry of judgment.

Appellees made no record demand for judgment here.

19. Appellants' petition for an interlocutory appeal creates no prejudice to Appellee.

20. There is no preclusion on appealed Orders that have not been litigated.

21. It may be a waste of judicial resources to try a case before a jury when Appellants have already declared they will ultimately appeal the "bad faith" insurance preemption.

22. There is no evidence to support a denial of Appellant's petition to Amend.

23. Subject matter jurisdiction is ambiguous, pending Rule 26 disclosures here.

24. The statutory violations at issue are subject to strict scrutiny.

WHEREAS, Appellants hereby move this court to grant an interlocutory appeal on Orders appealed at 05-1717 and 05-2527; and Appellants will be prejudiced if this honorable court does not grant interlocutory appeal, prior to rule 26 disclosures. Therefore, Appellant respectfully moves this appeal court to enter an order accepting Appellant's interlocutory appeals, filed at 05-1717 and 05-2527.

Respectfully submitted,
/s/Mary Ellen Chajkowski, Esquire
Counsel for Appellants

May 31, 2005

**IN THE UNITED STATES DISTRICT
IN THE WESTERN DISTRICT OF PENNSYLVANIA**

DONNA SCHEIBLER and
WILLIAM SCHEIBLER, her husband,
Plaintiff(s),

v.

HIGHMARK BLUE SHIELD,
Defendant(s)

PLAINTIFFS' MOTION FOR JUDICIAL RECUSAL

AND NOW come the Plaintiffs, by and through their attorney, Mary Ellen Chajkowski, Esquire, to hereby Move the district court, in the person of the Honorable Thomas Hardiman, to Recuse himself from presiding over this civil action:

1. A Motion for Recusal is appropriate and should be granted when a Judge shows bias toward one party such that judicial rulings and remarks made during the course of litigation display deep-seated favoritism or antagonism, such as would prejudice that party. Liteky v. United States, 510 U.S. 555, 556 (1994). In this case, the judicial bias here has prejudiced the Plaintiffs.

2. March 1, 2005, the District Court ordered the parties' counsel to appear for oral argument March 10, 2005, where the Defendant's denial that it was an employee benefits plan insurer was restated. (Exhibit A).

3. The district court personalized its remarks regarding Plaintiff's counsel, using '*your case*' and '*your client*' while the district court used '*Defendants*,' the proper procedural term, in reference to Defendants (Exhibit B, at p.3, L.21).

4. The district court stated that it held oral argument so as to “*explain in as genteel a way as possible*” that Plaintiffs’ counsel had entered “*unorthodox*” and “*inappropriate pleadings*.” (Exhibit B).

5. The district court erred, as quoted in paragraph 4 above, as the district court was referring to Petitions and Motions entered by Plaintiffs’ counsel, which were not “*pleadings*,” according to Fed. R. Civ. P. 7(a).

6. The district court has not enforced Fed. R. Civ. P. 26, requiring informational disclosures, to date; instead, the district court entered a Court Rules Order on January 14, 2005. (Record).

7. Non-enforcement of Rule 26 has prevented Plaintiffs from ascertaining whether additional defendants should be joined.

8. Despite *dismissing, with prejudice*, Plaintiffs’ state law bad faith claim under *Barber v. Unum Life Ins. Co. of America*, 383 F.3d 134 (3d Cir. 2004)(ERISA preemption of Pennsylvania state insurance bad faith law), the district court has insisted that Plaintiffs’ appeal is interlocutory and punished Plaintiff accordingly, by refusing to grant Plaintiff’s Petition for an Extension of time to Amend (Exhibit B).

9. The district court stated March 10, 2005, that dismissal of Plaintiffs’ bad faith claim with prejudice functions as a final adjudication on the merits. (Exhibit A).

10. The district court’s refusal to grant Plaintiffs’ Petition for an Extension of Time to Amend has prejudiced Plaintiffs by not allowing them to join their securities and antitrust claims arising out of the same transaction as the

ERISA claim, which may wrongfully give rise to later defenses of preclusion and/or *res judicata*.

11. The district court *sua sponte* qualified Defendant Highmark as an ERISA insurer at a hearing March 10, 2005, contrary to Defendant's written pleading, a violation of Plaintiffs' due process on a material issue. (Exhibit A, 92b, p. 8, lines 11-17).

12. The district court admonished Plaintiffs' counsel with the prospect of Rule 11 sanctions for appealing the district court's dismissal, with prejudice, of Plaintiffs' state bad faith claim (Exhibit A at 92b, p. 9, line 22).

13. The district court's Rule 11 admonishment, if intended to chill the advocacy of Plaintiffs' counsel constitutes judicial prejudice to Plaintiffs' claim for punitive damages as failure to appeal the district court's dismissal, with prejudice, may render that dismissal a final decision on the merits.

14. In its February 1, 2005, Memorandum Opinion, the district court prejudiced Plaintiffs when it applied *Mitchell v. Cellone*, No. 01-2028, 2003 U.S. Dist. LEXIS 22347, at *6 (W.D.Pa. November 71, 2003), and stated the district court would not accept *unwarranted inferences*, inconsistent with the court's statement acknowledging Plaintiffs' *undisputed allegation* that Defendant profited by denying coverage and later submitting a claim for full state reimbursement on Plaintiff's surgery (Exhibit C).

15. Application of *Mitchell*, to this set of facts, demonstrates district court bias against Plaintiffs' counsel and prejudicial effect toward Plaintiffs' claim (Id.).

16. The district court, by entering decisions as to evidence at the pleading stage, where discovery has not yet taken place, functions to unduly limit Plaintiff's scope of discovery (Exhibit C) and admission of relevant, probative evidence.

WHEREAS, for cause shown by the foregoing reasons, Plaintiff reasonably believes that the district court, in the person of the Honorable Thomas Hardiman, demonstrated, through judicial remarks and rulings, a bias sufficiently serious, as to result in prejudice to Plaintiff. Therefore, in the interest of fair and impartial application of the laws, Plaintiff moves the Honorable Thomas Hardiman, in his capacity as presiding judge, to Recuse himself from this civil action.

WHEREFORE, the Plaintiffs, unduly prejudiced by prolonged litigation, further request an expedited hearing and that the relief requested be granted on an expedited basis.

Respectfully submitted,

Mary Ellen Chajkowski, Esquire

June 8, 2005

**IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF PENNSYLVANIA**

**DONNA SCHEIBLER and
WILLIAM SCHEIBLER, her husband,
Plaintiff(s),**

v.

**HIGHMARK BLUE SHIELD,
Defendant(s).**

**PLAINTIFFS' REPLY TO DEFENDANT'S
RESPONSE TO MOTION FOR RECUSAL**

AND NOW come the Plaintiffs, Donna Scheibler and William Scheibler, her husband, by and through their attorney, Mary Ellen Chajkowski, Esquire, to hereby Reply to Defendant, Highmark's Response to Plaintiffs' Motion for Judicial Recusal.

1. Plaintiffs ask the district court to fully consider the fact that Defendant chose not to respond to every item in Plaintiffs' Motion, which must be construed in favor of Plaintiffs.

2. Defendant's Counsel asserted it had not received a copy of Plaintiffs' Motion but has nevertheless responded to it. Moreover, Plaintiffs mailed Defendant a copy of the motion June 8, 2005, as stated in the certificate of service.

3. In Plaintiffs' Motion, Plaintiffs seek recusal of Judge Thomas Hardiman, the federal court judge before whom this case has proceeded.

4. In Plaintiffs' Motion for Judicial Recusal, Plaintiffs have set forth a factual and legal basis for the recusal of Judge Hardiman.

5. Defendant cites 28 U.S.C. §§ 144 and 455 as the relevant statutory provisions regarding judicial recusal.

6. The language of 28 U.S.C. § 144 is unclear as to whether it refers to a judicial officer recusing himself or being disqualified.² If 28 U.S.C. §144 does apply to a judicial officer's self-recusal, Plaintiffs' Motion for Judicial Recusal acts as the affidavit required under this section. Plaintiff reasonably makes this request in good faith based upon the record,

7. Where Defendant cites authority requiring that "a reasonable person would conclude that a personal as distinguished from a judicial bias exists." Defendant's Response ¶ 7, citing *United States v. Enigwe*, 155 F.Supp.2d 365, 369 (E.D.Pa. 2001). Plaintiff argues that the bias stems from an extrajudicial source: the Judicial Officer's apparent animosity and personal dislike toward Plaintiffs' Counsel. However, because this section is unclear as to whether it applies to the instant case, it should not apply. Thus, the precedent cited by Defendant would be inapposite.

² Whenever a party to any proceeding in a district court makes and files a timely and sufficient affidavit that the judge before whom the matter is pending has a personal bias or prejudice either against him or in favor of any adverse party, such judge shall proceed no further therein, but another judge shall be assigned to hear such proceeding.

The affidavit shall state the facts and the reasons for the belief that bias or prejudice exists, and shall be filed not less than ten days before the beginning of the term at which the proceeding is to be heard, or good cause shall be shown for failure to file it within such time. A party may file only one such affidavit in any case. It shall be accompanied by a certificate of counsel of record stating that it is made in good faith.

8. Recusal is appropriate pursuant to 28 U.S.C. 455(a)³, which provides that a judicial officer should

³ (a) Any justice, judge, or magistrate judge of the United States shall disqualify himself in any proceeding in which his impartiality might reasonably be questioned.

(b) He shall also disqualify himself in the following circumstances:

(1) Where he has a personal bias or prejudice concerning a party, or personal knowledge of disputed evidentiary facts concerning the proceeding;

(2) Where in private practice he served as lawyer in the matter in controversy, or a lawyer with whom he previously practiced law served during such association as a lawyer concerning the matter, or the judge or such lawyer has been a material witness concerning it;

(3) Where he has served in governmental employment and in such capacity participated as counsel, adviser or material witness concerning the proceeding or expressed an opinion concerning the merits of the particular case in controversy;

(4) He knows that he, individually or as a fiduciary, or his spouse or minor child residing in his household, has a financial interest in the subject matter in controversy or in a party to the proceeding, or any other interest that could be substantially affected by the outcome of the proceeding;

(5) He or his spouse, or a person within the third degree of relationship to either of them, or the spouse of such a person:

(i) Is a party to the proceeding, or an officer, director, or trustee of a party;

(ii) Is acting as a lawyer in the proceeding;

(iii) Is known by the judge to have an interest that could be substantially affected by the outcome of the proceeding;

disqualify himself where his impartiality might reasonably be questioned. This part is disjunctive with 455(b), which involves personal bias or prejudice concerning a party. Only one need be true rather than both. Moreover, whether a judicial officer's impartiality might be questioned is an objective test: it is not whether the judge believes this to be true, but whether the reasonable person would believe it to be true. *Clemmons v. Wolfe*, Docket No. 02-4457 at 3 (3d Cir. 2004)(**marked as precedential**).

9. Plaintiffs' allegations offer evidence as to extrajudicial bias and thus are sufficient as a matter of law. For example, comments referred to in Plaintiffs' Motion for Judicial Recusal reflect a personal animosity and bias toward Plaintiffs' Counsel. The comment referred to in Motion Paragraph 4, which describes Plaintiffs' course of action as "unorthodox," and where the Judge goes on to describe this course of action as frivolous. However, Defendant has filed no motions regarding these allegedly frivolous pleadings; moreover, there is no record of Defendant's discontent. Finally, Judge Hardiman may know of reasons for extrajudicial bias, as his words and actions demonstrate, of which Plaintiffs are not specifically aware.

10. Even if the examples cited in Plaintiffs' Motion demonstrating uneven use of "you" and "your" are incorrect or insufficient, Plaintiffs' Motion contains various other examples which demonstrate bias toward Plaintiffs.

11. Fed.R.Civ.P. 26 requires an initial disclosure. Although the Court entered its Rules Order January 14, 2005 and Plaintiffs did not appeal the dismissal of the state law bad faith claim until March 3, 2005, and Defendant submitted its

(iv) Is to the judge's knowledge likely to be a material witness in the proceeding.

Answer and Affirmative Defenses February 16, 2005, no disclosure had occurred.

12. Although the Court's bias is shown through rulings and actions made in the course of litigation, they demonstrate a deeper bias toward Plaintiffs' Counsel. Thus, a reasonable person knowing all the circumstances may harbor doubts concerning Judge Hardiman's impartiality toward this action.

13. Where Plaintiffs have set forth evidence such that a reasonable person may harbor doubts as to the Court's impartiality, Plaintiffs' Motion for Judicial Recusal should be granted.

WHEREFORE, Plaintiffs, Donna Scheibler and William Scheibler, reasonably believe that sufficient factual and legal basis exists for the Honorable Thomas Hardiman to recuse himself, Plaintiffs submit this Reply to Defendant's Response to Plaintiffs' Motion for Judicial Recusal.

Respectfully submitted,

Mary Ellen Chajkowski
Attorney for the Plaintiffs

June 28, 2005

**UNITED STATES COURT OF APPEALS FOR THE
THIRD CIRCUIT - No. 05-1717**

Scheibler vs. Highmark Blue Sheild

**QUESTIONS PRESENTED FOR “*EN BANC*”
APPELLATE REVIEW**

I.

Whether Appellants’ substantive right to due process warrants this appellate court’s exercise of jurisdiction to hear an interlocutory appeal, under 28 U.S.C. section 1292(b), as a recent decision by a panel of the Third Circuit binds the district court to preempt a neutral state law intended to regulate and sanction an insurer’s “bad faith” failure to process insurance claims? Barber v. Unum Life, 383 F.3d 134 (3d Cir. 2004).

II.

Whether ERISA preemption of state claims for “bad faith” medical insurance violations will alter the practice of medicine for “plan” participants in the Third Circuit?

III.

Whether the Third Circuit application of preemption to an employee insured’s “pooled” allocation of risk for medical insurance coverage warrants *en banc* review to distinguish it from an employer insured’s “contractual” allocation of risk accepted in purchasing a group disability insurance policy; at a minimum requiring that an insurer respond to Complaint allegations that it failed to provide a written appeal procedure and failed to process its insured’s medical coverage claim in “good faith” pursuant to 42 Pa. C.S. Section. 8371, prior to litigating an insured’s ERISA civil enforcement claim?

PROCEDURAL SUMMARY

Appellant filed a Petition for Reconsideration of the February 1, 2005 order, which granted Appellee's Motion to Dismiss based on ERISA preemption and dismissed with prejudice Appellant's state law claim against Appellee for "bad faith" insurance violation. Appellant's Petition cited:

- 1) the absence of a qualified "approved plan" to enforce under ERISA⁴
- 2) Appellee's failure to specify "plan" language excluding Appellant's coverage;
- 3) Appellee's failure to cite any written appeal procedure available to Appellant;
- 4) Appellee's May 17, 2004 letter, which contradicts its ERISA liability denial.

The district court ordered Appellee to respond to the Petition for Reconsideration. Appellee filed non-responsive pleadings denying ERISA liability based on a contract with Appellant's employer. However, Appellee did not attach that contract to its pleading. Procedurally, Appellee's contradictory Motion to Dismiss based on preemption and its pleadings denying ERISA liability based upon contract are impermissible. Procedurally, Appellee eviscerated Appellant's due process and punitive damages claim.

The district court failed to give precedence to Appellant's right to due process and it failed to construe all facts alleged in Appellant's favor, facts which permit Appellant recovery for "bad faith" punitive damages against Appellee, where an ERISA "plan" relationship between the parties is void and ERISA civil enforcement is not applicable.

⁴ (see Appellant's Complaint Exhibit A)

FACTUAL SUMMARY

Appellant William Scheibler was diagnosed with cancer shortly after returning from active duty in the Gulf War. Appellee provided medical coverage for Appellant's tonsillar carcinoma, his 1997 radical neck dissection, depression and cancer treatment, including extensive radiation that finally necessitated oral surgery in 2004. Therefore, Appellee knowingly and callously disregarded Appellants' treating physician letters, which detailed the medical necessity of Appellant's surgery.

Appellant Donna Scheibler selected Appellee from medical insurers offered by her employer, as Appellee insured William Scheibler prior to disability from his own employment. Appellant participates with employer in payment for her family's coverage.

Appellant's Petition for Reconsideration alleged that Appellee's May 17, 2004 written statement that Appellee did an appropriate medical review were not supported by documentary evidence (See Complaint Exhibit A), to which Appellee failed to respond with specificity understood by the participants. Appellee breached its regulatory duty to offer Appellants a written appeal procedure, therefore there was no ERISA due process in place for Appellants to contest Appellee's unwarranted denial of medical coverage.

Appellee approved payment of Appellant's preoperative hyper baric treatments but denied coverage for Appellant's surgery, an unnecessary delay that compromised Appellant's limited ability to heal from the oral surgery. Appellee's delayed denial of medical coverage occasioned unnecessary pain, suffering and economic losses.

Appellee knew or should have known, through its own records, that Appellant William Scheibler suffered more

than ten years from disabling illness, disfigurement, depression and economic hardship. Appellee denied coverage and Appellants paid for the oral surgery, which created economic chaos in their family.

In response to Appellant's Complaint, Appellee filed pleadings that procedurally eviscerated Appellant's "bad faith" state insurance claim, first filing a Motion to Dismiss the state claim based on preemption, which the district court granted. Appellee then filed pleadings denying ERISA liability based upon an unspecified contract with the employer.

DISCUSSION

I. Material disputed facts were not litigated in the case *sub judice*. Therefore, Appellant's substantive right to due process may not be barred by preemption.

Appellants' substantive right to due process and equal protection of the law must be given full force and effect to support a valid district court decision. All state legislation must pass state constitutional muster to be enacted. The Pennsylvania constitution can afford more due process protection to its citizens than the United States Constitution, which the district courts must strictly construe in favor of the insureds, as the ERISA protected class of persons, when preemption adversely effects their rights.

Congress expressly created a Savings Clause to make an exception to preemption for state laws that regulate insurance, securities and banking. 42 Pa. C.S. sec. 8371 is an insurance law that neutrally regulates insurance, which is distinctly different from the Texas statute at issue in Aetna Health Inc. v. Davila, 124 S. Ct. 2488 (2004). The Supreme Court applied preemption where HMO insureds challenged plan prescription benefits by trying to incorporate an HMO's

duty to 'exercise ordinary care' under state law. The Davila insured was denied coverage for a name brand prescription drug and filed suit for injury sustained by taking alternate medication. The insurer provided notice that the Davila insured's physician had not sought pre-certification, but that the plan would cover Vioxx if the Davila insured's physician indicated that the less costly drug was contraindicated. The insurer's letter provided a list of alternative medications available under the plan's formulary without pre-certification, as well as the grievance and independent review procedures available to the Davila insured. *Id.* In contrast, Appellee provided no alternatives and no appeal procedure to Appellants.

The Pennsylvania Supreme Court extended Pennsylvania's common law to include claims for bad faith in the context of insurer's failure to use good faith in settling cases filed against the insured. Birth Center v. St. Paul Companies, Inc., 567 Pa. 386 (2001), which may extend to an insurer's failure to process a claim in good faith. Appellee had an independent duty, defined by ERISA regulations, to provide written notice of its medical coverage denial; in terms of sufficient specificity to be understood by the participant; and to set forth its appeal and review process to Appellants. Therefore, Appellee breached its ERISA regulated duty and its duty under state insurance law.

II. Appellants present a compelling reason for *en banc* review, as "plan" participants will be treated inequitably in the Third Circuit if preemption bars "bad faith" claims of 'plan' insureds only.

Third circuit "plan" insureds are entitled to equitable application of state laws regulating insurance claims. If "plan" insureds are inequitably and routinely preempted from pursuing their right to litigate claims for an insurer's bad

faith denial of medical coverage, a disturbing pattern will emerge in medical care for "plan" insureds. For example, medical decisions for "plan" insureds may become compromised by "plan" exclusion language drafted by insurers.

The question of medical necessity is determined objectively as being in accordance with general medical practice. That may become compromised for "plan" insureds whose insurers become insulated from sanctions for "bad faith" by preemption.

Appellants' right to litigate common law claims for punitive damages for Appellee's 'reckless disregard for the rights of the Appellants' and Appellee's undisputed 'unjust enrichment' at the expense of Appellants are not abrogated by their "plan" status.

Recovery under a reasonable extension of statutory relief would create more certainty.

III. There are substantive reasons for the Third Circuit Court of Appeals to grant *en banc* review to its application of the U.S. Supreme Court's two prong preemption test to Appellant employee's "bad faith" medical insurance claim.

Disputed material facts distinguish Appellants claim from Barber, where an employee's "bad faith" claim against insurer for coverage denied under a group disability policy purchased by employer was held preempted by ERISA.

1) The "pooled" risk in medical insurance coverage and Appellants' shared payment with employer for coverage, qualify for the preemption exception.

2) The allocation of risk was defined by "contract" in a group disability policy purchased by the employer in Barber and the preemption exception did not apply.

3) Losses for medical payments made by Appellee are state subsidized, while Appellant's economic losses are not state subsidized.

4) Appellant was denied coverage for medically necessary oral surgery by Appellee whose 2004 reserves were over two billion dollars and whose wholly owned dental insurance subsidiary, United Concordia, brought in over one billion dollars in revenue in 2004, as the fifth largest dental insurer in the United States.

5) State subsidy to health insurers is intended to cover the state's uninsured and underinsured and to neutrally protect the economic interest of all insureds who pay for medical coverage, without exception for 'plan' coverage.

6) Pursuant to the ERISA savings clause and 42 Pa. C.S. section 8371, the 1990 state legislature intended to regulate Appellee, an insurer that it subsidizes, and to sanction and deter Appellee's "bad faith" failure to process claims for all insureds.

7) The ERISA savings clause creates an express exception for state regulation of insurance, securities and banking. Therefore, 42 Pa. C.S. section 8371 punitive damages may be considered as an upward deviation of compensatory damages.

8) The Appellants' allocation of risk was substantially effected by Appellee, which meets the requirements for the Miller exception to preemption.

CONCLUSION

Appellants qualify for both prongs of the Miller test 538 U.S. 329 (2003), as Appellee's denial of medical coverage substantially effected and disrupted the risk pool. Second, there is no approved "plan" to enforce under ERISA. Third, Appellants have endured duress and will be unnecessarily prejudiced by prolonged appellate litigation. Fourth, the state has a substantial interest in enforcing 42 Pa. C.S. section 8371 against bad faith actions of insurers who deny medical coverage that the state subsidizes. Fifth, Appellants allegation that Appellee was unjustly enriched by denying coverage and submitting Appellant's bill for reimbursement was not disputed by Appellee.

WHEREAS, the district court failed to take all facts alleged and any responses thereto, including Appellee's failure to respond, in favor of Appellant. The facts, if proven, support Appellants' claims which will entitle them to relief precluding dismissal.

WHEREFORE, Appellant respectfully petitions the Third Circuit Court of Appeals to do an *en banc* review of preempting 42 Pa. C.S. section 8371, the state bad faith insurance law, as it applies to medical insurance coverage.

Respectfully Submitted,

Mary Ellen Chajkowski, Esquire
Counsel for Appellants

**IN THE UNITED STATES COURT OF APPEALS
FOR THE THIRD CIRCUIT**

Nos. 05-1717 & 05-2527

DONNA SCHEIBLER and
WILLIAM SCHEIBLER, her husband, :
Appellant(s).

v.

HIGHMARK BLUE SHIELD,
Respondent(s).

**APPELLANTS'
PETITION FOR REHEARING *EN BANC***

AND NOW, come the Appellants, by and through their attorney, Mary Ellen Chajkowski, Esquire to Petition this Honorable Court to Review *en banc* this Court's July 26, 2005 Order dismissing Appellants' appeal for lack of finality and, thus, subject matter jurisdiction.

1. Appellants express a belief, based on a reasoned and studied professional judgment by their Counsel, that the panel's Decision dismissing Appellant's appeals for lack of appellate jurisdiction, implicates a question of exceptional importance, including the Plaintiffs' constitutional due process rights, of which review at a later point would raise insurmountable obstacles to proper remedy, as an excluded claim cannot be reinstated upon appellate review at the end of the litigation.

2. Appellants, as "plan insured" members of the protected class of persons, within the express language of ERISA and Pennsylvania's bad faith insurance regulatory statute at 42

Pa. C.S. Section 8371, filed a Complaint which alleged that Appellee Insurer's denial of coverage constituted a violation of the federal and state statutes and Appellant's substantive right to due process, which requires *strict scrutiny* appellate review.

3. Appellant seeks *en banc* appellate review of its panel decision preempting Pennsylvania's bad faith law at 42 Pa. C.S. Sec. 8371, in Barber v. Unum Life, 383 F.3d 134 (3d Cir. 2004), which may have erred in extending preemption of a dissimilar state law in Kentucky Ass'n of Health Plans, Inc. v. Miller, 123 S. Ct. 1471 [30 EBC 1129] (2003) to Pennsylvania's bad faith insurance law.

4. Barber v. Unum Life, 383 F.3d 134 (3d Cir. 2004) an interlocutory appeal taken under 28 U.S.C. section 1292(b), decided by a panel of this Court, inequitably and adversely preempts "plan insureds" only from civil enforcement of Pennsylvania's neutral bad faith insurance statute, a violation of federal constitutional Equal Protection.

5. Appellants' substantive right to due process warrants this appellate court's exercise of jurisdiction to hear *en banc* an interlocutory appeal, under 28 U.S.C. section 1292(b), as a recent decision by a panel of the Third Circuit binds the district court to preempt a neutral state law intended to regulate and sanction an insurer's "bad faith" failure to process insurance claims. Barber v. Unum Life, 383 F.3d 134 (3d Cir. 2004).

6. Appellant's federal protection here includes the Department of Labor Regulations, requiring notice, specificity in denial, and a written appeal procedure, in order to qualify Appellee to first establish "ERISA standing" before filing its motion to dismiss Appellant's "bad faith" insurance claim which did not happen here.

7. The Sixth Circuit in Adkins cited World-Wide Volkswagen Corp. v. Woodson, 444 U.S. 286 (U.S. 1980), where it held that “a judgment rendered in violation of due process is void in the rendering State and is not entitled to full faith and credit elsewhere.” Woodson at 291, quoted in Adkins, 2005 WL 486670 at 5.

8. Appellant’s right to due process takes precedence over procedural requirements that an Order be certified, within the meaning of 28 U.S.C. 1291; and warrants an interlocutory appeal, under 28 U.S.C. 1292(b).

9. Appellant must not be sanctioned where the district court failed to certify its order, where statements made by the court to the parties assert its intent to be final, as Appellant’s claims were **dismissed with prejudice**.

10. Appellant’s appeal under 05-1717 petitions the district court to note the ambiguity regarding Appellee’s standing, and therefore the court’s jurisdiction, where Appellee:

- A) Files a motion for dismissal based on ERISA preemption;
- B) Then denies being an ERISA insurer in its Answer filed after dismissal;
- C) Admits making certain payments on behalf of its insured but denies that it made the decisions in refusing certain other payments, including surgery.
- D) Where Appellee failed to deny that it profited by seeking full reimbursement.

11. The ambiguity surrounding Appellee’s standing and the court’s subject matter jurisdiction were created by the district court’s failure to enforce Rule 26 from the outset.

12. Appellants' substantive right to due process and equal protection of the law must be given full force and effect to support a valid district court decision. All state legislation must pass state constitutional muster to be enacted.

13. The Pennsylvania constitution can afford more due process protection to its citizens than the United States Constitution, which the district courts must strictly construe in favor of the insureds, as the ERISA protected class of persons, when preemption adversely effects their rights.

14. Congress expressly created a Savings Clause to make an exception to preemption for state laws that regulate insurance, securities and banking. 42 Pa. C.S. sec. 8371 is an insurance law that neutrally regulates insurance, which is distinctly different from the Texas statute at issue in Aetna Health Inc. v. Davila, 124 S. Ct. 2488 (2004). The Supreme Court applied preemption where HMO insureds challenged plan prescription benefits by trying to incorporate an HMO's duty to 'exercise ordinary care' under state law. The Davila insured was denied coverage for a name brand prescription drug and filed suit for injury sustained by taking alternate medication. The insurer provided notice that the Davila insured's physician had not sought pre-certification, but that the plan would cover Vioxx if the Davila insured's physician indicated that the less costly drug was contraindicated. The insurer's letter provided a list of alternative medications available under the plan's formulary without pre-certification, as well as the grievance and independent review procedures available to the Davila insured. Id. In contrast, Appellee provided no alternatives and no appeal procedure to Appellants.

15. The Pennsylvania Supreme Court extended Pennsylvania's common law to include claims for bad faith in the context of insurer's failure to use good faith in settling cases filed against the insured. Birth Center v. St. Paul

Companies, Inc., 567 Pa. 386 (2001), which may extend to an insurer's failure to process a claim in good faith. Appellee had an independent duty, defined by ERISA regulations, to provide written notice of its medical coverage denial; in terms of sufficient specificity to be understood by the participant; and to set forth its appeal and review process to Appellants. Therefore, Appellee breached its ERISA regulated duty and its duty under state insurance law.

16. Appellants present a compelling reason for *en banc* review, as "plan" participants will be treated inequitably in the Third Circuit if preemption bars "bad faith" claims of 'plan' insureds only.

17. Third Circuit "plan" insureds are entitled to equitable application of state laws regulating insurance claims. If "plan" insureds are inequitably and routinely preempted from pursuing their right to litigate claims for an insurer's bad faith denial of medical coverage, a disturbing pattern will emerge in medical care for "plan" insureds. For example, medical decisions for "plan" insureds may become compromised by "plan" exclusion language drafted by insurers.

18. The question of medical necessity is determined objectively as being in accordance with general medical practice. That may become compromised for "plan" insureds whose insurers become insulated from sanctions for "bad faith" by preemption.

19. Appellants' right to litigate common law claims for punitive damages for Appellee's 'reckless disregard for the rights of the Appellants' and Appellee's undisputed 'unjust enrichment' at the expense of Appellants are not abrogated by their "plan" status. Recovery under a reasonable extension of statutory relief would create more certainty.

20. There are substantive reasons for the Third Circuit Court of Appeals to grant *en banc* review to its application of the U.S. Supreme Court's two prong preemption test to Appellant employee's "bad faith" medical insurance claim.

21. Disputed material facts distinguish Appellants claim from Barber, where an employee's "bad faith" claim against insurer for coverage denied under a group disability policy purchased by employer was held preempted by ERISA.

1) The "pooled" risk in medical insurance coverage and Appellants' shared payment with employer for coverage, qualify for the preemption exception.

2) The allocation of risk was defined by "contract" in a group disability policy purchased by the employer in Barber and the preemption exception did not apply.

3) *Losses for medical payments made by Appellee are state subsidized, while Appellant's economic losses are not state subsidized.*

4) Appellant was denied coverage for medically necessary oral surgery by Appellee whose 2004 reserves were over two billion dollars and whose wholly owned dental insurance subsidiary, United Concordia, brought in over one billion dollars in revenue in 2004, as the fifth largest dental insurer in the United States.

5) State subsidy to health insurers is intended to cover the state's uninsured and underinsured and to neutrally protect the economic interest of all insureds who pay for medical coverage, without exception for 'plan' coverage.

6) Pursuant to the ERISA savings clause and 42 Pa. C.S. section 8371, the 1990 state legislature intended to regulate Appellee, an insurer that it subsidizes, and to sanction and deter Appellee's "bad faith" failure to process claims for all insureds.

7) The ERISA savings clause creates an express exception for state regulation of insurance, securities and banking. Therefore, 42 Pa. C.S. section 8371 punitive damages may be considered as an upward deviation of compensatory damages.

8) The Appellants' allocation of risk was substantially effected by Appellee, which meets the requirements for the Miller exception to preemption.

22. If Appellants' due process and equal protection rights are not protected by granting jurisdiction for this appeal at this stage of the litigation, they will lose important rights for which later appeal will afford no adequate remedy.

23. The District Court Order has not been entered, nor would the District Court Judge grant an allowance for interlocutory appeal, because the District Court Judge harbors animosity toward Appellant's Counsel, a Writ of Mandamus to issue a *Recusal* ruling is presently before this court.

WHEREFORE, Appellant respectfully petitions the Third Circuit Court of Appeals to rehear *en banc* Appellant's appeal of the District Court dismissal of Appellants' punitive damages claim by preempting 42 Pa. C.S. section 8371, the state bad faith insurance law, as it applies to medical insurance coverage.

Appellant's Amended and Corrected
Petition for *en banc* Rehearing

24. Paragraphs one (1) through (23) twenty-three are hereby incorporated.
25. Appellants' counsel hereby amends and corrects Appellants' Petition for a Rehearing *en banc* and submits the following:
 - a) a Rule 35.1 required statement;
 - b) a copy of the Order appealed;
 - c) a copy of Appellee's request for additional defendant without court order;
 - d) a copy of the court's compliance letter;
 - e) a copy of the 05-2527 docket showing Appellee out of compliance 6/6/05.
26. Appellant reasonably believes that appellate jurisdiction lies, as the 05-1717 appeal is from a final order and that the 05-2527 appeal is from a collateral order.
27. Appellee did not file a petition to have the order certified as final; the district court stated that "with prejudice" meant finality; and Appellant, prejudiced by the court's failure to certify the order, appeals based on substantive finality.
28. The district court stated that it granted Appellant thirty days to Amend and denied Appellant an extension of time to Amend in opposition to the appeal at 05-1717, making the order at 05-2527 a collateral order to 05-1717.

29. Appellant's Petition for a Writ of Mandamus requesting action on Appellant's Motion for Recusal, is pending action before this court.
30. The court's Compliance letter to Appellant inequitably failed to list the least restrictive "strike the document" option available under the sanctions rule.
31. Appellees inequitably received no Compliance letter from the Clerk for failing to comply with the court's June 6, 2005 directive.
32. Appellants Petition for *en banc* Rehearing was mailed 08/09/05, within 14 days.
33. Appellee did not argue prejudice and filed no request for sanctions on Appellant.
34. Imposition of sanctions on Appellant and or dismissal of this action would prolong litigation, an unnecessary duress on Appellants and may be constitute bad faith; pretext for bias; or inequitable application of the rules, a violation of the fourteenth amendment. "Procedural due process rules are meant to protect persons not from deprivation, but from mistaken or unjustified deprivation of life, liberty or property." U.S.C.A. Const. Amend. 14. Carey v. Piphus, 435 U.S. 247 (1978).
35. August 11, 2005, Appellee's counsel filed a request to include an additional defendant, without requesting a hearing or a court order.

36. Appellant reasonably believes the panel erred in relying on Quackenbush v. Allstate, 517 U. S. 707, 712 (1996), as the holding in Quackenbush is limited to actions seeking common-law damages that are in federal court by way of diversity jurisdiction. Coles, et al v. Street, 38 Fed. Appx. 829 (3rd Cir. 2002).

WHEREAS, Appellant has provided substantive reasons to grant its Petition for Rehearing *en banc* of the July 26, 2005 Order; and Appellant has shown cause to file Appellant's Amended/Corrected document; and Appellant hereby moves this honorable court for leave to file Appellant's Amended/Corrected Petition for Rehearing and to grant Appellant's Petition for a Rehearing *en banc* to review medical coverage issues of great importance to insured individuals, medical care providers and healthcare administrators in the Third Circuit.

Respectfully Submitted,

Mary Ellen Chajkowski, Esquire

**IN THE COURT OF COMMON PLEAS OF
WESTMORELAND COUNTY, PENNSYLVANIA
Civil Division No. cv 05- 7642**

DONNA SCHEIBER,
Plaintiff,

vs.

HIGHMARK BLUE SHIELD; and jointly, separately, or
severally,
KEYSTONE HEALTH PLAN WEST, d/b/a Security Blue,
Defendant(s).

COMPLAINT IN CIVIL ACTION

AND NOW, comes the Plaintiff, Donna Scheibler, by and through her attorney, Mary Ellen Chajkowski, Esquire, and files the following COMPLAINT IN CIVIL ACTION against Highmark Blue Shield; and jointly, separately or severally, Keystone Health Plan West, d/b/a Security Blue, to claim damages from Defendant(s) in addition to the medical coverage she purchased for her family, by making co-payments through her employment, and represents the following in support thereof:

Jurisdiction - 42 Pa. C.S.A. s 8371

This action is brought under, and jurisdiction is vested in this Court through 42 Pa. C.S.A. s 8371, Pennsylvania Bad Faith Statute, which regulates the insurance industry, mandating accountability on the part of all insurance companies for any frivolous or unfounded refusal to provide coverage in accordance with an applicable policy of insurance.

Parties

1. Plaintiff DONNA SCHEIBLER is an adult individual who resides in Westmoreland County, mailing address: RD #2, Box 468, Greensburg, PA 15601.

2. Defendant(s) HIGHMARK BLUE SHIELD; and *jointly, separately, or severally*, KEYSTONE HEALTH PLAN WEST, d/b/a Security Blue, which do business in Pennsylvania and are headquartered at Fifth Avenue Place, Pittsburgh, PA 15222.

Privity

3. Plaintiff Donna Scheibler, as an employee of ABB, Inc., is enrolled as a beneficiary of the company's health care benefits *plan*. Plaintiff's family is entitled to the benefits of the health care *plan*.
4. Plaintiff Donna Scheibler selected Highmark Blue Shield, from several providers offered to ABB employees, makes co-payment with her employer.
5. Plaintiff Donna Scheibler selected Highmark Blue Shield for her family, as William Scheibler, her husband, needed to maintain continuous coverage with the same insurer he had prior to disability in 1995 (*deceased in 2005*).
6. At all times relevant hereto, the Defendant(s), Highmark Blue Shield and/or Keystone Health Plan West, d/b/a Security Blue, provided health care insurance pursuant to employee benefit *plans* on behalf of ABB employee/Plaintiff Donna Scheibler.
7. Defendant(s), Highmark Blue Shield and/or Keystone Health Plan West, d/b/a Security Blue, are employee benefits *plan* insurer(s) in the State of Pennsylvania.
8. Highmark Blue Shield offers an address for its Member Grievance & Appeals Department at P.O. Box 535095, Pittsburgh, PA 15253-5095 (Exhibit A).

Re: Plaintiff v. Highmark at 04-cv-1928

Count I ERISA/Count II Bad Faith

9. Defendant(s) failed to avail themselves of federal jurisdiction to litigate either claim; Defendant(s) created ambiguity about 'standing' by unilaterally naming a second defendant after its motion to dismiss as preempted; and, a later Answer in contradiction.

10. Plaintiff named two Defendant entities based unlitigated actions, averments and admissions or waiver made in federal court by Defendants 04-cv-1928 WD

Control Group

11. In 2004, Defendant Highmark reported to the public:

- a) Profits in excess of three hundred nine million dollars;
- b) 'Blues' reserves of four billion dollars, two billion dollars held by Highmark 2004;
- c) Highmark's top executive paid 1.7 million dollars;
- d) Fewer than ten Highmark's top executives paid eight (8) million dollars total 2004;
- e) A wholly owned dental insurance subsidiary earned one billion dollars in revenue 2004.

13. By operation of law, Defendant(s), its fiduciaries, affiliates and assignees have:

- a) Constructive Notice to conform to Department of Labor (DOL) regulations;
- b) A duty to provide due process understood by *plan* claimants; and
- c) Actual Notice of non-compliance, pursuant to Plaintiff's federal lawsuit.

Therefore, its failure to investigate, resolve, settle or fully litigate constituted bad faith.

14. Defendant(s) acted as a control group on behalf of both named defendants:

- a) Highmark's May 2004 letter to Plaintiff authorized ERISA appeals;

- b) Highmark moved to dismiss the 42 Pa. S8371 bad faith claim, as preempted;
 - c) Highmark's Answer then denied that it is an ERISA insurer;
 - d) Highmark's Answer referred to a contract with ABB and did not attach it;
 - e) Highmark attempted to add a second defendant by correspondence;
 - f) Highmark failed to avail itself of federal jurisdiction to litigate either claim.
15. Defendant(s) control group(s) is/are composed of a small number of highly compensated executives, subject to the authority of one or more board(s) of directors.
16. Defendant(s) fund the *plan*, assign risk, set rates and approve or deny claims.
17. Plaintiff reasonably believes that information on Defendant(s) constitution(s), by-laws, articles of incorporation, Boards and self-governance are material to this claim.

Compliance

18. Approved *plan* documents and written appeal procedures are compliance requirements; without which, coverage is whatever Defendant(s) arbitrarily decide.
19. Defendants' failure to approve ABB's August 2003 'Plan draft' and its failure to offer a written appeal procedure render exclusionary language unenforceable.
20. Plaintiff hereby reserves the right to Amend this _____ Complaint to conform to evidence within the exclusive control of Defendant(s), as multiple statutory violations

regulating benefit *plans* were revealed in Plaintiff's 2004 un-litigated federal action.

Savings Clause

21 Plaintiff's bad faith claim is a Pennsylvania action, as the Savings Clause' insurance, securities and banking exceptions to federal preemption apply here.

22. Plaintiff reposed her trust in Defendant(s) by co-paying for medical coverage. Here, bad faith denial constitutes a 'securities' exception to preemption, where coverage denied as 'dental' v. medical, constitutes self-dealing by state subsidized entities whose wholly owned dental insurance subsidiary generated one billion dollars in 2004 revenue.

Bundling

23. Defendant Highmark's Answer admitted making certain 2004 payments on Plaintiff's claim but denied making the decision to deny the surgery claim, without revealing the identity of, or relationship to, the entity that did make the decision.

24. Defendant(s) exercise(s) coercive influence over the medical insurance market, where provisions bundled in contracts may be enforced to unilaterally drop employer groups or individuals pursuant to Defendant(s) unilateral mandatory provisions.

25. Defendant(s) failure to disclose all affiliates/subsidiaries in the federal action; and decision to edit Plaintiff's federal caption, by court correspondence, are evidence of 42 Pa. C.S.A. s8371 'bad faith' and control group *scienter* in contesting Plaintiff's claim.

Privacy

26. Plaintiff reasonably believes and therefore avers that her family's constitutional and statutory (HIPPA) right to privacy was compromised by Defendant(s).

27. The privacy violation came to light upon the death of Plaintiff's husband.

28. Plaintiff's family medical records were made available to insurers who denied coverage based on medical records available at the time coverage was approved.

29. Insurers in 2005 may have confused Plaintiff's husband's medical history with Plaintiff's deceased father in law, as the birth date, name and address were similar.

30. Plaintiff was never apprised of contracts between employer and Defendant(s), which made her family medical records accessible to Defendant(s) affiliates and others.

Intended and/or Foreseeable Consequences

31. William Scheibler, a Gulf War special forces veteran, was disabled from employment with ABB in March 1995 with health benefits covered by Defendant(s).

32. Defendant(s) covered and paid medical expenses related to Mr. Scheibler's cyst, a heart attack and stroke, *tonsillar carcinoma* and a radical neck dissection in 1997.

33. William Scheibler was not forewarned that extensive facial bone deterioration was a likely risk related to 1997 radiation treatments administered on his neck; however, Defendant(s) knew or should have known the consequence of delayed surgery.

34. In January 2004, William Scheibler's treating physicians wrote letters to Defendant Highmark, attributing William Scheibler's need for oral surgery to extensive radiation treatments that were administered for his *tonsillar carcinoma*, stating that the surgery is medically necessary.

In a letter to Defendant Insurer, Dr. Stephen Rendulich attributed William Scheibler's caries to *xerostomia*:

"Radiation induced caries should be treated as a late effect medical condition resulting from radiation therapy. Having hyperbaric oxygen prior to dental extractions would significantly decrease his risk of *osteoradionecrosis*, which, as you know, can be quite extensive in nature, resulting in the loss of jaw and significant dysfunction and deformity, requiring multiple operations to correct."

35. Defendant(s) possess expert knowledge to adequately assess medical necessity and knew, or should have known that Plaintiff's claim was medically necessary.

36. Defendant(s) knowingly made frivolous determinations on Plaintiff's claim.

37. Defendant Highmark approved payment of William Scheibler's pre-op and post-op, Hyperbaric Oxygen hospital treatments, done in preparation for surgery.

- a) William Scheibler was told authorization for surgery follows.
- b) Four weeks, Monday-Friday, Scheibler drove into Pittsburgh for Hyperbaric Oxygen treatments, ending in March 2004.
- c) No authorization for surgery came,
- d) No timely written denial came,
- e) Scheiblers submitted Highmark appeal forms several times,

Misrepresentations to Congress

38. William Scheibler wrote to Pennsylvania United State Senators and his Congressman, whose offices made written inquiries to Defendant(s) on his behalf.

39. Plaintiff reasonably believes and therefore avers that Defendant(s) vague, written responses to elected federal officials constituted misrepresentations to Congress, an unconscionable act by state subsidized entities who were not in statutory compliance.

40. Defendant Highmark's May 2004 letter, asserting that Plaintiff's claim went before a review committee, was not supported by its documentation of that assertion.

41. Defendant(s) denied payment for Scheibler's surgery, scheduled March 2004, in May 2004, an egregious delay, as the untimely denial based on unspecified language.

**Defendant(s)' Statutory Violations
Caused Harm to Plaintiff's Family**

42. Plaintiff's employment with ABB succeeded her husband's disability and provided an opportunity to maintain Defendant(s) health care coverage continuously.

43. For a period of years, prior to the events giving rise to this cause of action, William Scheibler was reasonably mobile; he enjoyed his life, his wife, school activities of their two adolescent sons, and his extended family living nearby.

44. January 2004, William Scheibler's physician requested authorization.

45. May 2004, Defendant(s) unilaterally refused to authorize payment for surgery in the dentist's office, after it approved the pre-op hospital treatments months before.

46. Defendant Highmark's state subsidy is not a dollar for dollar exchange of services for money, hospital state subsidy is based on a formulaic equation,

including past losses. Highmark was not in statutory compliance to deny Plaintiff's claim, yet displayed a flagrant disregard for Plaintiff's rights under the law in the federal litigation:

- a) Highmark filed a Motion to Dismiss Plaintiff's bad faith claim based on ERISA;
- b) Highmark later filed an Answer, which denied ERISA liability;
- c) Highmark admitted it paid selected Scheibler medical bills;
- d) Highmark denied decision-making on coverage;
- e) Highmark attempted to change Plaintiff's caption by correspondence;
- f) Highmark's control group failed to correct its compliance errors;
- g) Highmark afforded Plaintiff's claim no due process, even in court;
- h) Highmark failed to resolve or litigate both claims, bad faith and ERISA.

Count I – Specific Performance
Plaintiff v. All Defendant(s)

47. Paragraphs 1 through 46 are hereby incorporated as if more fully set forth at full length herein.

WHEREFORE, plaintiff prays:

- a) that defendant(s) be ordered to specifically perform its agreement to authorize payment of all medical expenses related to this claim, under the applicable coverage co-paid by Plaintiff's through employer;
and,
- b) such other general relief as may be just and proper.

Count II – Dereliction of a Duty to Deal in Good Faith
Plaintiff v. All Defendant(s)

48. Paragraphs 1 through 47 are incorporated as if set forth at full length herein.

49. Defendant(s) had a statutory duty to deal with Plaintiff in good faith, pursuant to 42 Pa. CSA s 8371 which neutrally regulates insurance, a savings clause exception; however, when state laws are preempted, courts have upheld duties by regulation to protect *plan* claimants that include DOL regulations requiring, *inter alia*:

- a) timely Notice to claimant,
- b) alternative treatment offered,
- c) written grievance and independent review procedures;
- d) physician over-ride provisions; and
- e) all of the above to be understood by the participant.

See Aetna Health Inc. v. Davila, 124 S. Ct. 2488 (2004).

- f) Defendant(s) control group breached the above Compliance duties here.

50. Plaintiff asserts that statutory compliance duties were breached, which Defendant(s) control group willfully refused to correct in federal litigation, in bad faith.

51. Defendant(s) conduct in failing to honor medical bills constituted bad faith, in that it was a breach of a known duty, timely with the duty of good faith and fair dealing, and that it was done through a motive of self-interest or ill-will.

52. Under the above circumstances, the Plaintiffs are entitled to recover benefits due Plaintiff under the

terms of the plan, to enforce the rights under the terms of the plan, and to clarify the rights to future benefits under the term of the plan.

53. While said policy was in full force and effect, Plaintiff requested approval of benefits for her husband's oral surgery, a procedure which was recommended by his treating physician as medically necessary.
54. All conditions precedent under this policy have been performed by Plaintiff.
55. Defendant(s) failed to pay the plaintiff the sum of money due under the policy.
56. Statutory violations of medical insurers, utilizing state subsidized insurance that is funded and regulated by the legislature, must be equitably enforced by the courts; specifically, *Plan* claimant and non-*Plan* claimant rights must be adjudicated equitably. As a result of the dereliction of duty to deal in good faith on the part of the Defendant(s), Plaintiff seeks special damages for Plaintiff's economic losses and harms caused by Defendant(s), including interest, punitive damages, costs and attorneys' fees.

WHEREFORE, Plaintiff demands judgment against the Defendant(s) for the reimbursement of medical care, plus interest, cost and attorney's fees, due and owing Plaintiff for the wrongful denial of coverage for William Scheibler's 2004 surgery; and requests this honorable court enter judgment in plaintiff's favor in excess of \$25,000.00

Count III – Bad Faith 42 Pa. CSA s 8371
Plaintiff v. All Defendant(s)

57. Paragraphs 1 through 56 are hereby incorporated as if more fully set forth at full length herein.
58. Defendant(s) 2004 failure to pay for William Scheibler's surgery caused him unnecessary pain and suffering, including disfigurement, and depression, which caused emotional and financial hardship on Plaintiff, his wife, their sons and Scheibler's family.
59. William Scheibler's physicians requested approval in January 2004.
60. William Scheibler became reclusive as his teeth started to fall out; he ate tapioca to ameliorate the pain and was frustrated, which altered his enjoyment of life.
61. Relying in good faith that surgery would be approved based on Defendant(s) approval of pre-op and post-op procedures, William Scheibler traveled to a Pittsburgh hospital for four weeks, Monday to Friday, for pre-op hyperbaric oxygen treatments,
62. William Scheibler's surgery was scheduled two weeks after the pre-op treatments ended, which Defendant(s) know is recommended for optimal healing.
63. The scheduled surgery was delayed for months after hyperbaric treatments, delay so remote from pre-op treatment that it caused difficulty in healing.
64. The delayed surgery caused additional delay before dentures could be fitted.

65. Plaintiff negotiated with the hospital and paid an agreed upon price for the surgery but later received statements that far exceeded the costs actually paid; in contrast, the physician fees were the same, whether covered or not covered.
66. The hospital fees were substantially varied when not covered.
67. Plaintiff realized a mortgage insurance loss in 2005 upon her husband's death.
68. Plaintiff refinanced the family home to pay for medical expenses, which cancelled William Scheibler's mortgage insurance before he died, insurance taken when he was not disabled, insurance he could not qualify for in 2004 to refinance.
69. The Pennsylvania Bad Faith Statute, 42 Pa. C.S.A. s 8371, regulates the insurance industry mandating accountability on the part of all insurance companies for any frivolous or unfounded refusal to provide coverage in accordance with an applicable policy of insurance.
70. Plaintiff avers that the Defendant(s) acted in bad faith in its actions toward her in handling the claim generally, and as set forth in the following particulars:
 - (a) In failing to consider all relevant factors and medical records to evaluate and determine the medical necessity of the surgery recommended by William Scheibler's treating physicians;

- (b) In failing to properly inform Mr. Scheibler of what constitutes medical necessity and why it believed his condition did not rise to that level;
- (c) In failing to appreciate the success of the surgery, as evidence of the necessity of the procedure;
- (d) In failing to pay for a covered benefit given the medical evidence presented.

WHEREFORE, Plaintiff requests, pursuant to 42 Pa. C.S.A. s 8371, an award of punitive damages, court costs and counsel fees to be paid by the Defendant(s).

**Count IV – Unjust Enrichment
Plaintiff v. All Defendant(s)**

71. Paragraphs 1 through 70 are hereby incorporated as if more fully set forth at full length herein.

72. Plaintiff, never apprised of a contract between employer and Defendant(s), reasonably believes and hereby asserts that fee sharing and similar incentives, offered by Defendant(s)' unilateral contract terms, are bundled with denied claims for profit.

72. Defendant(s) refused to authorize payment for office surgery in addition to the pre-op and post-op hyperbaric oxygen hospital treatments it authorized, as hospital surgery is state subsidized, a publicly funded source of profit to Defendant(s).

73. Defendant(s) frivolous approval of William Scheibler's pre-surgery hospital treatments combined with its arbitrary refusal to authorize payment for surgery, under the

same applicable coverage, and its failure to timely and explicitly notify Plaintiff of the same, constitute profitable compliance/bad faith violations at Plaintiff's expense.

75. Defendant(s) wrongfully requested and accepted state subsidy for William Scheibler's surgery, as he paid for it in full by prior agreement with the hospital.

76. Defendant(s) control group willfully failed to make corrections pursuant to Actual Notice, when Plaintiff filed a federal civil action.

77. Defendant(s) failure to deny Plaintiff's federal Complaint allegation that Defendant realized a profit by claiming and accepting state subsidy for Plaintiff's surgery, must be construed against Defendant(s); enrichment at the expense of Plaintiff.

WHEREFORE, Plaintiff demands a judgment against defendant(s) in the amount defendant(s) received as a result of defendant(s) wrongful acts and the return of all property unjustly retained by defendant(s).

Count V – Violation of the Unfair Trade Practices Act

78. Paragraphs 1 through 77 are hereby incorporated as if more fully set forth at full length herein.

79. Defendant(s) actions constitute an unfair method of competition and/or unfair or deceptive act or practice, as prohibited by Pennsylvania Law.

80. Defendant(s) actions constitute a violation of the Unfair Trade Practices Act and Consumer Protection Law.

81. As a result of the Defendant(s) violation of the Unfair Trade Practices Act and Consumer Protection Law, Plaintiff has suffered harm in that she has incurred medical expenses, which should have been covered by the policy, as well as consequential damages.

WHEREFORE, the Plaintiff respectfully requests this Honorable Court enter Judgment in Plaintiff's favor and against the Defendants in an amount in excess of \$25,000.00 (twenty five thousand dollars), for bad faith and consequential damages.

Respectfully submitted,
/s/Mary Ellen Chajkowski, Esquire
Counsel for Plaintiff Donna Scheibler

October 4, 2005

IN THE COURT OF COMMON PLEAS OF
WESTMORELAND COUNTY, PENNSYLVANIA
CIVIL DIVISION - No. 05- 7642

DONNA SCHEIBLER

Plaintiff,

vs.

HIGHMARK BLUE SHIELD; and jointly, separately, or
severally

KEYSTONE HEALTH PLAN WEST, d/b/a Security Blue,
Defendant(s).

PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT

NOTICE TO PLEAD

**To: Highmark Blue Shield; and
Keystone Health Plan West,**

You are hereby notified to file a written response to
the enclosed Motion for Summary Judgment within
thirty (30) days from service hereof or a judgment
may be entered against you.

*/s/Mary Ellen Chajkowski, Esquire,
Counsel for Plaintiffs.*

**IN THE COURT OF COMMON PLEAS OF
WESTMORELAND COUNTY, PENNSYLVANIA**

DONNA SCHEIBER,
Plaintiff,

vs.

HIGHMARK BLUE SHIELD; and jointly, separately, or
severally,
KEYSTONE HEALTH PLAN WEST, d/b/a Security Blue,
Defendant(s).

Plaintiff's Motion for Summary Judgment

AND NOW, comes the Plaintiff, Donna Scheibler, by and through her attorney, Mary Ellen Chajkowski, Esquire, and files the following Motion for Summary Judgment against Highmark Blue Shield; and jointly, separately or severally, Keystone Health Plan West, d/b/a Security Blue, to claim damages from Defendant(s) in addition to the medical coverage she purchased for her family, and represents the following in support thereof:

Jurisdiction - 42 Pa. C.S.A. s 8371

1. This action is brought under, and jurisdiction is vested in this Court through 42 Pa. C.S.A. s 8371, the Pennsylvania Bad Faith Statute, which regulates the insurance industry, mandating accountability on the part of all insurance companies for any frivolous or unfounded refusal to provide coverage in accordance with an applicable insurance policy.
2. The state has an interest in enforcement, as this law neutrally regulates insurance claims and the Pennsylvania legislature pays subsidy to Defendants for health insurance.

3. Federal courts refuse to entertain Plaintiff's 42 Pa. C.S.A. §8371 state claim.
4. State court affords a forum for Plaintiff to enforce statutory rights under this law.

Parties

5. Plaintiff DONNA SCHEIBLER is an adult individual who resides in Westmoreland County, mailing address: RD #2, Box 468, Greensburg, PA 15601.
6. Defendant(s) HIGHMARK BLUE SHIELD; and *jointly, separately, or severally*, KEYSTONE HEALTH PLAN WEST, d/b/a Security Blue, do business in Pennsylvania and are headquartered at Fifth Avenue Place, Pittsburgh, PA 15222.
7. Plaintiff's counsel signed a Notice to Plead on the cover page of this Motion.

Pa. Rule 1035.2, 1035.3(d) Motion for Summary Judgment

8. Defendants accepted service of Plaintiffs' Complaint October 17, 2005.
9. Defendants filed no Answer within twenty days; the pleadings are closed.
10. Plaintiffs' physicians requested coverage January 2004, which Defendants denied May 2004, after ambiguously approving related hospital expenses.
11. Plaintiff William Scheibler relied on Defendants' approval of pre-op hyperbaric oxygen treatments,

traveling to forty miles to a hospital, four weeks in March 2004.

12. Defendants denied coverage for office surgery, as dental not medical, then requested and accepted state reimbursement in excess of costs paid by Plaintiffs, who filed suit in December 2004; Count I ERISA and Count II Bad Faith (Exhibit A).
13. Defendant Highmark moved for dismissal of the bad faith claim based on Pre-emption (Exhibit B); then filed an Answer (Ex. C) non-responsive to Bad Faith allegations, denying it is an ERISA insurer, based on a contract which it did not attach.
14. Plaintiffs were prejudiced by federal courts' refusal to hear the state bad faith claim; and by Defendants failure to Answer bad faith allegations of both Complaints.
15. Plaintiffs' Complaint was filed October 4, 2005.
16. Defendants' accepted service of the Complaint on October 17, 2005.
17. Twenty days have lapsed and Defendants filed no Answer.
18. Twenty days having lapsed, the pleadings are closed.
19. Plaintiff herein files a Motion for Summary Judgment; and a supporting Brief.
20. Plaintiff requests Oral Argument on the Motion, Pursuant to local rule 1035.2(c).

WHEREFORE, Plaintiffs' filed a Complaint on October 4, 2005 and Defendants accepted Sheriff Service of the Complaint October 17, 2005; twenty days have lapsed and no Answer filed, the pleadings are closed. Plaintiff herein files a Motion for Summary Judgment and a supporting Brief, requesting Oral Argument *on the Motion*, pursuant to local rule of procedure 1035.2(c), in conformity rules 1035.2 and 1035.3(d) of the Pennsylvania rules of procedure.

Respectfully submitted,

/s/Mary Ellen Chajkowski, Esquire
Counsel for the Plaintiffs

November 9, 2005

**IN THE COURT OF COMMON PLEAS OF
WESTMORELAND COUNTY, PENNSYLVANIA**

DONNA SCHEIBLER,
Plaintiff,

vs.

HIGHMARK BLUE SHIELD; and jointly, separately, or
severally,
KEYSTONE HEALTH PLAN WEST, d/b/a Security Blue,
Defendant(s).

**PLAINTIFF'S BRIEF SUPPORTING THE
MOTION FOR SUMMARY JUDGMENT**

AND NOW, comes the Plaintiff, Donna Scheibler, by and through her attorney, Mary Ellen Chajkowski, Esquire, and files the following brief supporting Plaintiffs' Motion for Summary Judgment against Highmark Blue Shield; and jointly, separately or severally, Keystone Health Plan West, d/b/a Security Blue, and represents the following in support:

Jurisdiction - 42 Pa. C.S.A. s 8371

This action is brought under, and jurisdiction is vested in this Court through 42 Pa. C.S.A. s 8371, the Pennsylvania Bad Faith Statute, which regulates the insurance industry, mandating accountability on the part of insurance companies for any frivolous or unfounded refusal to provide coverage in accord with applicable policy of insurance.

Standards Applicable to the Parties

Plaintiff is a statutory 'protected person' subject to strict scrutiny for enforcement of Pennsylvania's 'bad faith' insurance law. Defendants are subject to a heightened arbitrary and capricious review here, as insurers. Defendants are fiduciary entities by statute and decision makers as contemplated in Pinto v. Reliance Standard Life Ins. Co.,

214 F. 3d 377,378 (3d Cir. 2000), where this appeal court held insurers to a standard of review commensurate with their duty: “when a [an insurance] company both funds and administers benefits, it is generally acting under a conflict that warrants a heightened form of the arbitrary and capricious standard of review. *Id.*

Plaintiffs’ Opportunity to Be Heard

Under the Fourteenth Amendment, due process mandates that once a state has created rights or benefits, these benefits may not be stripped away without due process of law. Fuentes v. Shevin, 407 U.S. 67, 81 (1972). Plaintiff has a statutory right to be heard on the ‘bad faith’ claim. Without an opportunity to be heard, Defendants are unjustly enriched at Plaintiffs expense.

The constitutional right to be heard is a basic aspect of the duty of government to follow a fair process of decision-making when it acts to deprive a person of his possessions. The purpose of this requirement is not only to ensure abstract fair play to the individual. Its purpose, more particularly, is to protect his use and possession of property from arbitrary encroachment—to minimize substantively unfair or mistaken deprivations of property, a danger that is especially great when the State seizes goods simply upon the application of and for the benefit of a private party. So viewed, the prohibition against the deprivation of property without due process of law reflects the high value, embedded in our constitutional and political history, that we place on a person’s right to enjoy what is his, free of governmental interference. *Id.*—

Defendants’ Waiver Strategy

Defendants knowingly waived its opportunity to litigate Plaintiff’s bad faith claim in federal court, creating an undue economic prejudice to Plaintiff, which the state court has jurisdiction and a constitutional duty to correct.

“Procedural due process rules are meant to protect persons not from deprivation, but from mistaken or

unjustified deprivation of life, liberty or property." U.S.C.A. Const. Amend. 14. Carey v. Piphus, 435 U.S. 247 (1978) citing Boddie v. Connecticut, 401 U.S. 371, 375 (1971). "The right to procedural due process is 'absolute' in the sense that it does not depend upon the merits of a claimant's substantive assertions, and because of the importance to organized society that procedural due process be observed, we believe that the denial of procedural due process should be actionable without proof of actual injury." Id. Defendants' waiver strategy and failure to litigate or resolve this claim is further evidence of statutory bad faith.

Respectfully submitted,
/s/Mary Ellen Chajkowski, Esquire
Filed on behalf of Plaintiff
November 9, 2005

Supreme Court, U.S.

05 - 645 101 18 2005

No. 05-

OFFICE OF THE CLERK

In The

Supreme Court of the United States

DONNA SCHEIBLER, and
WILLIAM SCHEIBLER, her husband,
Insured Plaintiff,

Petitioner,

v.

HIGHMARK BLUE SHIELD,
Insurer, defendant,

THOMAS J. HARDIMAN,
United States District Court Judge,

Respondents.

On Petition for *Writ of Certiorari* to the
United States Court of Appeals for the Third Circuit

Appendix III – Respondent Pleadings

Mary Ellen Chajkowski, Esquire
Petitioner's Counsel of Record
Pennsylvania ID# 86611
5510 Hobart Street
Pittsburgh, PA 15217
412-904-2222

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IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF PENNSYLVANIA

DONNA SCHEIBLER and WILLIAM
SCHEIBLER, her husband,

Plaintiffs,

v.

HIGHMARK BLUE SHIELD,
Defendant.

No. 04-1928

Judge Hardiman

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DEFENDANT'S MOTION TO DISMISS

NOW COMES Defendant Highmark Blue Shield ("Highmark"), by its attorneys, Gerri L. Sperling, Brian P. Fagan and Springer Bush & Perry P.C., and hereby moves this Honorable Court to dismiss Count II of Plaintiffs' Complaint pursuant to Fed.R.Civ.P. 12(b)(6) for failure to state a claim upon which relief can be granted, and in support hereof, Highmark sets forth the following:

I. PRELIMINARY AVERMENTS

1. Plaintiffs commenced this action by filing a Complaint in Civil Action (the "Complaint"), on December 23, 2004.
2. Highmark was served with a copy of the Complaint on January 3, 2005.
3. Plaintiffs allege in the Complaint that Plaintiff Donna Scheibler is an employee of ABB, Inc. ("ABB") and that she is enrolled as a beneficiary of ABB's health care benefits plan

(the "Plan"). Plaintiffs further allege that her husband, Plaintiff William Scheibler ("William") is also entitled to benefits under the Plan. (Complaint, ¶4).

4. Plaintiffs allege that "[a]t all times relevant hereto, [Highmark] provided health care insurance pursuant to an employee benefit plan on behalf of the Plaintiff, Donna Scheibler." (Complaint, ¶7).

5. Plaintiffs allege that William was diagnosed with cancer for which he underwent radiation treatment in 1997. (Complaint, ¶8). William's treating physician indicated that oral surgery was medically necessary to treat William's "radiation induced caries" condition, as a result of the radiation treatments administered for his cancer. (Complaint, ¶ 9).

6. Plaintiffs claim that Highmark approved pre- and post-operative hyperbaric oxygen treatments to be performed in anticipation of William's oral surgery, but denied payment for the surgery itself. (Complaint, ¶¶10, 11).

7. Plaintiffs appealed Highmark's denial of coverage, allegedly exhausting all administrative appeals. (Complaint, ¶¶14, 19).

8. William proceeded with his scheduled surgery, negotiating a payment to the hospital that was far less than the actual billed charges set forth on later billing statements. (Complaint, ¶16).

9. Plaintiffs claim that Highmark "may have benefited by denying coverage to [William], for payment of his hospital costs and later accepting reimbursement in excess of the agreed upon payment actually made." (Complaint, ¶17).

10. Plaintiffs seek to recover from Highmark damages that they allegedly suffered as a result of Highmark's denial of benefits under the Plan to cover the costs of William's surgery. Plaintiff Complaint sets forth two causes of action in the following Counts:

Count I - Employee Retirement Income Security Act (ERISA), 29 U.S.C. §1132(a)(1)(B).

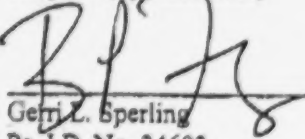
Count II - Pennsylvania Bad Faith Statute, 42 Pa.C.S.A. § 8371.

II. MOTION TO DISMISS PURSUANT TO FED.R.CIV.P. 12(b)(6)

11. Plaintiffs' cause of action for bad faith pursuant to Pennsylvania's Bad Faith statute, 42 Pa.C.S.A. §8371, is completely and expressly preempted by §§ 502(a) and 514(a) of ERISA, 29 U.S.C. §§ 1132(a) and 1144(a).

WHEREFORE, Defendant Highmark Blue Shield respectfully requests that this Court enter an Order dismissing Count II of Plaintiffs' Complaint.

Respectfully submitted,



Gerri L. Sperling
Pa. I.D. No. 34603

Brian P. Fagan
Pa. I.D. No. 72203

SPRINGER BUSH & PERRY P.C.
Firm No. 271
Two Gateway Center, 15th Floor
Pittsburgh, PA 15222-1402

412-281-4900

Attorneys for Defendant Highmark Blue Shield

Dated:

1/13/05

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF PENNSYLVANIA

DONNA SCHEIBLER and WILLIAM
SCHEIBLER, her husband,

Plaintiffs,

No. 04-1928

v.

Judge Hardiman

HIGHMARK BLUE SHIELD,
Defendant.

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DEFENDANT'S BRIEF IN SUPPORT OF MOTION TO DISMISS

I. PRELIMINARY AVERMENTS

Plaintiffs commenced this action by filing a Complaint in Civil Action (the "Complaint"), on December 23, 2004. Highmark was served with a copy of the Complaint on January 3, 2005.

Plaintiffs allege in the Complaint that Plaintiff Donna Scheibler is an employee of ABB, Inc. ("ABB") and that she is enrolled as a beneficiary of ABB's health care benefits plan (the "Plan"). Plaintiffs further allege that her husband, Plaintiff William Scheibler ("William") is also entitled to benefits under the Plan. (Complaint, ¶4). Plaintiffs allege that "[a]t all times relevant hereto, [Highmark] provided health care insurance pursuant to an employee benefit plan on behalf of the Plaintiff, Donna Scheibler." (Complaint, ¶7).

Plaintiffs allege that William was diagnosed with cancer for which he underwent radiation treatment in 1997. (Complaint, ¶8). William's treating physician indicated that oral surgery was medically necessary to treat William's "radiation induced caries" condition, as a result of the

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radiation treatments administered for his cancer. (Complaint, & 9). Plaintiffs claim that Highmark approved pre- and post-operative hyperbaric oxygen treatments to be performed in anticipation of William's oral surgery, but denied payment for the surgery itself. (Complaint, ¶¶10, 11).

Plaintiffs appealed Highmark's denial of coverage, allegedly exhausting all administrative appeals. (Complaint, ¶¶14, 19). William proceeded with his scheduled surgery, negotiating a payment to the hospital that was far less than the actual billed charges set forth on later billing statements. (Complaint, ¶16). Plaintiffs claim that Highmark "may have benefited by denying coverage to [William], for payment of his hospital costs and later accepting reimbursement in excess of the agreed upon payment actually made." (Complaint, ¶17). Plaintiffs seek to recover from Highmark damages that they allegedly suffered as a result of Highmark's denial of benefits under the Plan to cover the costs of William's surgery. Plaintiffs' Complaint sets forth two causes of action in the following Counts:

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Count I - Employee Retirement Income Security Act (ERISA), 29 U.S.C. §1132(a)(1)(B).

Count II - Pennsylvania Bad Faith Statute, 42 Pa.C.S.A. § 8371.

Concurrently herewith, Highmark has filed a Motion to Dismiss Count II of Plaintiffs' Complaint. In its Motion to Dismiss, Highmark seeks dismissal of the Complaint under Fed.R.Civ.P. 12(b)(6) because the state law claim set forth therein is completely and/or expressly preempted by ERISA. Highmark submits the instant Brief in support of its Motion to Dismiss.

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II. MOTION TO DISMISS PURSUANT TO FED.R.CIV.P. 12(b)(6)

Count II of Plaintiffs' Complaint purports to state a claim pursuant to the Pennsylvania bad faith statute, 42 Pa. C.S.A. § 8371, which provides remedies for bad faith denials of insurance claims.

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Recently, the Third Circuit in *Barber v. Unum Life Ins. Co. of America*, 383 F.3d 134, (3rd Cir. 2004), determined that Pennsylvania's bad faith statute is both conflict and expressly preempted by Sections 502(a) and 514(a) of ERISA, respectively. The *Barber* Court explained that conflict preemption applies to a state statute "if it provides 'a form of ultimate relief in a judicial forum that added to the judicial remedies provided by ERISA . . . or . . . if it 'duplicates, supplements, or supplants the ERISA civil enforcement remedy'." 383 F.3d at 140 (citations omitted). The *Barber* Court determined that "42 Pa.C.S. § 8371 is such a statute because it is a state remedy that allows an ERISA plan participant to recover punitive damages for bad faith conduct by insurers, supplementing the scope of relief granted by ERISA. Accordingly, 42 Pa.C.S. § 8371 is subject to conflict preemption." *Id.* at 140-41.

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Alternatively, the Third Circuit also held that Section 8371 is expressly preempted by Section 514(a) of ERISA. Section 514(a) provides that that ERISA "shall supersede any and all state laws insofar as they may now or hereafter relate to any employee benefit plan." 29 U.S.C. § 1144(a). A savings provision of the Act, however, excepts from pre-emption "any law of any State which regulates insurance, banking, or securities." 29 U.S.C. § 1144(b)(2)(A).

In *Barber*, the Third Circuit noted that the United States Supreme Court in *Kentucky Ass'n of Health Plans, Inc. v. Miller*, 538 U.S. 329, 123 S.Ct. 1471, 155 L.Ed.2d 468 (2003), articulated "a


two-part test which clarified that a statute 'regulates insurance' and satisfies the savings clause only if it (1) is 'specifically directed toward entities engaged in insurance' and (2) 'substantially affect[s] the risk pooling arrangement between the insurer and the insured'." *Barber*, 383 F.3d at 141, quoting *Miller*, 538 U.S. at 341-42.

As to the first prong of the *Miller* test, the Third Circuit found that Section 8371 does "regulate[] insurers' conduct by imposing industry-wide conditions on the insurance business." *Barber*, 383 F.3d at 142. The *Barber* Court concluded, however, that Section 8371 did not meet the second prong of the *Miller* test because: (1) the statute is remedial in nature and "does not affect the kinds of bargains insured and insurers may make"; (2) "claims for bad faith insurance breaches bear no relation to the risk pooled – the risk of loss the insurer agrees to bear on behalf of the insured"; and (3) "the threat that punitive damage awards may result in increased costs that could be passed on to the insured is too attenuated to be deemed to 'substantially affect' the risk pooling arrangement".

Id. at 143-44. Consequently, Pennsylvania's bad faith statute is both conflict and expressly preempted by ERISA and Count II of the Complaint should be dismissed.

WHEREFORE, Defendant Highmark Blue Shield respectfully requests that this Court enter
an Order dismissing Count II of Plaintiffs' Complaint.

Respectfully submitted,


Gail L. Sperling
Pa. I.D. No. 34603

Brian P. Fagan
Pa. I.D. No. 72203

SPRINGER BUSH & PERRY P.C.
Firm No. 271
Two Gateway Center, 15th Floor
Pittsburgh, PA 15222-1402

412-281-4900

Attorneys for Defendant Highmark Blue Shield

11...1
Dated: 9/3/05

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF PENNSYLVANIA

DONNA SCHEIBLER and WILLIAM
SCHEIBLER, her husband,

Plaintiffs,

v.

HIGHMARK BLUE SHIELD,
Defendant.

No. 04-1928

Judge Hardiman

COPY

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ANSWER AND AFFIRMATIVE DEFENSES

NOW COMES Defendant Highmark Blue Shield ("Highmark"), by its attorneys, Gerri L. Sperling, Brian P. Fagan and Springer Bush & Perry P.C., and answers Plaintiff's Complaint as follows:

FIRST DEFENSE - ANSWER TO PLAINTIFF'S COMPLAINT

1. Denied as stated. Pursuant to the Court's Order dated February 1, 2005, Plaintiff's state law claim was dismissed.
2. Admitted.
3. Admitted.
4. Admitted.
5. Admitted in part. It is admitted that Plaintiff Donna Scheibler selected a health care coverage provided by Highmark (the "Plan") pursuant to a health care contract between Plaintiff's employer, ABB, Inc., and Highmark. After reasonable investigation, Highmark is without

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knowledge or information sufficient to form a belief as to the truth of the remaining averments set forth in Paragraph 5 of Plaintiff's Complaint.

6. It is denied as stated that Highmark is an employee benefits plan insurer. It is admitted that Highmark maintains an address for its Member Service Department at P.O. Box 53509, Pittsburgh, PA 15253-5095.

7. Denied.

8. After reasonable investigation, Highmark is without knowledge or information sufficient to form a belief as to the truth of the remaining averments set forth in Paragraph 8 of Plaintiff's Complaint.

9. It is admitted that William Scheibler's physicians sent letters to Highmark indicating that his need for oral surgery was medically necessary. With regard to the averments set forth in Paragraph 9 of Plaintiff's Complaint which reference a letter from Dr. Rendulich to Highmark, such letter is a document which speaks for itself. Accordingly, no response to the averments as to the letter in this paragraph is required by Highmark.

10. Admitted in part. It is admitted that Highmark approved coverage for William Scheibler's Hyperbaric Oxygen treatments. After reasonable investigation, Highmark is without knowledge or information sufficient to form a belief as to the truth of the remaining averments set forth in Paragraph 10 of Plaintiff's Complaint.

11. Denied as stated. Highmark denied pre-approval of the scheduled surgery.

12. Admitted.

13. Denied.

14. Admitted in part. It is admitted that Highmark provided Plaintiffs' counsel with a copy of Plaintiff's benefits program booklet. After reasonable investigation, Highmark is without knowledge or information sufficient to form a belief as to the truth of the remaining averments set forth in Paragraph 14 of Plaintiff's Complaint.

15. After reasonable investigation, Highmark is without knowledge or information sufficient to form a belief as to the truth of the averments set forth in Paragraph 15 of Plaintiff's Complaint.

16. After reasonable investigation, Defendants are without knowledge or information sufficient to form a belief as to the truth of the averments set forth in Paragraph 16 of Plaintiff's Complaint.

17. After reasonable investigation, Defendants are without knowledge or information sufficient to form a belief as to the truth of the averments set forth in Paragraph 17 of Plaintiff's Complaint.

18. After reasonable investigation, Defendants are without knowledge or information sufficient to form a belief as to the truth of the averments set forth in Paragraph 18 of Plaintiff's Complaint.

19. Admitted.

COUNT I

Employee Retirement Income Security Act (ERISA), 29 U.S.C.S. § 1132(a)(1)(B)

20. In that Paragraph 20 of Plaintiff's Complaint incorporates by reference Paragraphs 1 through 19 thereof, Highmark incorporates herein its responses thereto as set forth hereinabove.

21. The averments set forth in Paragraph 21 of Plaintiff's Complaint are conclusions of law to which no response is required. To the extent that such averments constitute averments of fact, the averments therein that "Plaintiffs are entitled to recover benefits due them under the terms of the plan, to enforce the rights under the terms of the plan, and to clarify the rights to future benefits under the terms of the plan" are denied.

22. Admitted.

23. After reasonable investigation, Defendants are without knowledge or information sufficient to form a belief as to the truth of the averments set forth in Paragraph 10 of Plaintiff's Complaint.

24. The averments set forth in Paragraph 24 of Plaintiff's Complaint are conclusions of law to which no response is required. To the extent that such averments constitute averments of fact, the averment therein that Highmark "has failed to pay the Plaintiffs the sum of money due under the policy" is denied.

COUNT II

Pennsylvania Bad Faith Statute, 42 Pa.C.S. § 8371

25. In that Paragraph 25 of Plaintiff's Complaint incorporates by reference Paragraphs 1 through 24 thereof, Highmark incorporates herein its responses thereto as set forth hereinabove.

26. No response is required to Paragraph 26 of Plaintiff's Complaint pursuant to the Order of Court dated February 1, 2005, dismissing Count II thereof.

27. No response is required to Paragraph 27 of Plaintiff's Complaint pursuant to the Order of Court dated February 1, 2005, dismissing Count II thereof.

SECOND DEFENSE

28. The services and supplies requested on behalf of Mr. Scheibler for his oral surgery were not covered benefits under the Plan.

THIRD DEFENSE

29. Highmark properly considered and reviewed the claims for coverage requested on behalf of Mr. Scheibler pursuant to the terms of the Plan.

FOURTH DEFENSE

30. Highmark paid for all covered expenses incurred by or on behalf of Mr. Scheibler to which he was entitled as a beneficiary of the Plan.

FIFTH DEFENSE

31. Plaintiff and/or Mr. Scheibler failed to provide adequate documentation to reverse the decision of Highmark that the services requested on behalf of Mr. Scheibler were covered benefits under the Plan.

NINTH DEFENSE

32. Plaintiff has failed to state a claim for which relief can be granted.

TENTH DEFENSE

33. Any cause of action which Plaintiff is attempting to assert other than a claim under ERISA is preempted by ERISA.

ELEVENTH DEFENSE

34. Plaintiff has waived any claims that she and/or Mr. Scheibler may have had and/or such claims are barred by the doctrine of laches.

TWELFTH DEFENSE

35. Plaintiff's claims are barred in part or wholly by the applicable statute of limitations.

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WHEREFORE, Defendant Highmark BlueShield demands that Plaintiff's Complaint be dismissed and that judgment be entered in favor of Highmark and against Plaintiff.

Respectfully submitted,

RPZ

Gerri L. Sperling
Pa. I.D. No. 34603

Brian P. Fagan
Pa. I.D. No. 72203

SPRINGER BUSH & PERRY P.C.
Two Gateway Center, 15th Floor
Pittsburgh, PA 15222-1402
412-281-4900

Attorneys for Highmark BlueShield

Dated: *February 16, 2005*

27

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF PENNSYLVANIA

DONNA SCHEIBLER and WILLIAM
SCHEIBLER, her husband,

Plaintiffs,

v.

HIGHMARK BLUE SHIELD,
Defendant.

No. 04-1928

Judge Hardiman

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HIGHMARK'S BRIEF IN OPPOSITION TO
PLAINTIFFS' PETITION FOR RECONSIDERATION

I. BACKGROUND

Plaintiffs commenced this action by filing a Complaint in Civil Action (the "Complaint"),

on December 23, 2004. Plaintiffs allege in the Complaint that Plaintiff Donna Scheibler is an employee of ABB, Inc. ("ABB") and that she is enrolled as a beneficiary of ABB's health care benefits plan (the "Plan"). Plaintiffs further allege that her husband, Plaintiff William Scheibler ("William") is also entitled to benefits under the Plan. Plaintiffs' Complaint set forth two causes of action:

Count I - Employee Retirement Income Security Act (ERISA), 29 U.S.C. §1132(a)(1)(B).

Count II - Pennsylvania Bad Faith Statute, 42 Pa.C.S.A. § 8371.

On January 13, 2005, Highmark filed a Motion to Dismiss Count II of Plaintiffs' Complaint pursuant to Fed.R.Civ.P. 12(b)(6) on the basis that the state law claim set forth therein

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was completely and/or expressly preempted by ERISA. On February 1, 2005, this Court entered a Memorandum Opinion and accompanying Order dismissing Plaintiffs' state law bad faith claim in Count II of the Complaint, relying upon the recent decision of the Court of Appeals for the Third Circuit in *Barber v. Unum Life Ins. Co. of America*, 383 F.3d 134 (3rd Cir. 2004). As this Court noted, the *Barber* Court specifically held that sections 502(a) and 514(a) of ERISA preempt claims under the Pennsylvania bad faith statute, 42 Pa.C.S.A. § 8371.

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On or about February 10, 2005, Plaintiffs filed their Petition for Reconsideration of the Court's Order of February 1, 2005, alleging, *inter alia*, that "two material issues of fact preclude dismissal with prejudice: 1) Whether the "draft" plan is qualified; and, if it is qualified, 2) Whether the plan offers procedures that afford a reasonable opportunity for full and fair review of dispositions adverse to claimants." Petition for Reconsideration, p. 3.

II. ARGUMENT

Plaintiffs claim that this Court's dismissal of Count II of the Complaint "cut off Plaintiffs [sic] right to a full and fair review of defendant's denial of medical insurance coverage." Petition for Reconsideration, ¶ 1.¹ Plaintiffs also argue that the Court erred in applying the holding of *Barber* to the facts of this action because that case "addressed a group, long-term disability insurance policy, purchased by the employer, a contract with specific coverage/exclusions language." Petition for Reconsideration, ¶ 9. Plaintiffs fail to explain, however, why the type of

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¹ Plaintiffs also set forth various allegations concerning the characterization of Highmark's coverage as "qualified", Highmark's basis for denial of coverage of benefits sought on behalf of Mr. Scheibler, and whether a "draft" plan provided by Highmark to Plaintiffs "controls" and offers procedures that afford a reasonable opportunity of review of benefits determinations. Highmark is unclear how these allegations are implicated by the Court's dismissal of Count II based upon ERISA preemption doctrines, and how they might be considered in order to effect a reconsideration of the Court's decision. Count I of Plaintiffs' Complaint, which was not dismissed, alleges a cause of action under ERISA, pursuant to which Plaintiffs may yet challenge Highmark's actions under the Plan.

benefits plan (long term disability in *Barber* vs. health care coverage in the case *sub judice*) precludes ERISA preemption of Pennsylvania's bad faith statute.

By seeking to distinguish *Barber* on this basis, Plaintiffs misapprehend the doctrine of ERISA preemption. The type of plan does not inform a preemption analysis; rather, the type of relief or remedy sought controls the applicable analysis. In *Aetna Health Inc. v. Davila*, 539 U.S. 986, 124 S.Ct. 2488 (2004), the United States Supreme Court considered whether the plaintiffs there, as ERISA plan participants or beneficiaries, could recover under a Texas statute for the defendants' alleged failures to exercise ordinary care in the handling of coverage decisions. The Court of Appeals for the Fifth Circuit had held that the remedies available under the Texas statute (the "THCLA") were not preempted by ERISA because preemption only applies where "'States . . . duplicate the causes of action listed in ERISA' and 'because the THCLA does not provide an action for collecting benefits' it fell outside the scope of § 502(a)(1)(B)." *Id.* at 2494. *quoting Roark v. Humana, Inc.*, 307 F.3d 298, 310-311 (5th Cir. 2002).

The Supreme Court disagreed, stating "interpretation of the terms of respondents' benefit plans forms an essential part of their THCLA claim, and THCLA liability would exist here only because of petitioners' administration of ERISA-regulated benefit plans. Petitioners' potential liability under the THCLA in these cases, then, derives entirely from the particular rights and obligations established by the benefit plans. . . . Hence, respondents bring suit only to rectify a wrongful denial of benefits promised under ERISA-regulated plans, and do not attempt to remedy any violation of a legal duty independent of ERISA." *Aetna Health*, 124 S.Ct. at 2498.

Here, any alleged liability of Highmark derives solely from its coverage determinations made pursuant to the Plan. By attempting to state a claim under the Pennsylvania bad faith statute, Plaintiffs have not alleged a violation of a duty independent of ERISA. Simply stated, it makes no difference that the Plan at issue involves the provision of health care benefits and the plan in *Barber* involved long-term care benefits. It is the remedies available under Pennsylvania's bad faith statute that impermissibly conflict with and are expressly preempted by ERISA. In fact, *Aetna Health*, upon which the *Barber* Court relied, involved the denial of benefits under employee benefits health care plans similar to the one at issue here.² Thus, Plaintiffs' inexplicable argument that *Barber* is distinguishable on the basis that the type of employee benefit plan should control ERISA preemption doctrines is belied by the holding of *Aetna Health*.

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III. CONCLUSION


Plaintiffs have not offered any analysis or cited any authority for the proposition that *Barber* does not control here. Therefore, because Pennsylvania's bad faith statute is both conflict and expressly preempted by ERISA, this Court properly dismissed Count II of the Complaint.

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² The *Barber* Court, 383 F.3d at 138 n. 4, cited numerous District Court cases which found that Pennsylvania's bad faith statute was preempted by ERISA. These cases involved various employee benefit programs including those providing long-term disability, life insurance, retiree health care, and the following cases involving denials of coverage under health care plans like the one at issue. See, e.g., *Nguyen v. Healthguard of Lancaster, Inc.*, 282 F.Supp.2d 296 (E.D.Pa.2003) reconsideration denied 03- 3106, 2003 U.S. Dist. LEXIS 22043 (E.D.Pa. Oct. 7, 2003); *Spook v. Penn State Geisinger Health Plan*, 241 F.Supp.2d 485 (M.D.Pa.2003; *Sprechter v. Aetna U.S. Healthcare, Inc.*, 2002 WL 1917711 (E.D. Pa. 2002).

WHEREFORE, Defendant Highmark Blue Shield respectfully requests that this Court enter
an Order denying Plaintiffs' Petition for Reconsideration.

Respectfully submitted,



Gerri L. Sperling
Pa. I.D. No. 34603

Brian P. Fagan
Pa. I.D. No. 72203

SPRINGER BUSH & PERRY P.C.
Firm No. 271
Two Gateway Center, 15th Floor
Pittsburgh, PA 15222-1402

412-281-4900

Attorneys for Defendant Highmark Blue Shield

Dated: 2/23/05

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CERTIFICATE OF SERVICE

I, Brian P. Fagan, hereby certify that the foregoing document was served by first class United States mail, postage prepaid, upon the following counsel of record:

Mary Ellen Chajkowski, Esquire
5510 Hobart Street
Pittsburgh, PA 15217



Brian P. Fagan

Dated:

2/23/05

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IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF PENNSYLVANIA

DONNA SCHEIBLER and WILLIAM
SCHEIBLER, her husband,

Plaintiffs,

v.

HIGHMARK BLUE SHIELD,
Defendant.

No. 04-1928

Judge Hardiman

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RESPONSE TO PLAINTIFFS' MOTION FOR JUDICIAL RECUSAL

AND NOW, comes Highmark Blue Shield ("Highmark"), by and through its counsel, Gerri L. Sperling, Brian P. Fagan and Springer Bush & Perry P.C., and files the within Response to Plaintiffs' Motion for Judicial Recusal, stating as follows:

1. Plaintiffs filed their Motion for Judicial Recusal (the "Motion") on or about June 8, 2005.

2. Counsel for Highmark did not receive a copy of the Motion, although the Certificate of Service indicates service was made upon counsel on June 8, 2005. Counsel discovered the existence of the Motion by reference to it in a status report as to the instant action filed by Plaintiffs with the United States Court of Appeals for the Third Circuit.

3. In their Motion, Plaintiffs seek recusal of Judge Thomas Hardiman, the federal court judge before which this case has proceeded.

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4. Plaintiffs fail to set forth the legal basis or any facts in their Motion which would provide grounds for the recusal of Judge Hardiman.

5. Although not cited by Plaintiffs, the bases for the recusal of a federal judge are set forth at 28 U.S.C. §§ 144 and 455.¹

6. Plaintiffs have not filed an affidavit as required by Section 144, therefore, recusal is not appropriate under this provision. Even if the Court considers the allegations set forth in Plaintiffs' Motion in place of an affidavit required by Section 144, such allegations would not provide sufficient grounds for recusal.

7. "In evaluating a motion brought under [Section] 144, the 'test is whether, assuming the truth of the facts alleged, a reasonable person would conclude that a personal as distinguished from a judicial bias exists.'" *United States v. Esham*, 165 F.3d 23, 205, 206 (D.C. 2000).

United States v. Esham, 165 F.3d 23, 205, 206 (D.C. 2000).
quoting *Mims v. Shapp*, 541 F.2d 415, 417. "As a rule, only allegations of personal bias and prejudice will suffice and the bias or prejudice must stem from an extrajudicial source." *Id.* (citations omitted). "Extrajudicial bias is 'bias not derived from the evidence or conduct of the

¹ Section 144 provides:

Whenever a party to any proceeding in a district court makes and files a timely and sufficient affidavit that the judge before whom the matter is pending has a personal bias or prejudice either against him or in favor of any adverse party, such judge shall proceed no further therein, but another judge shall be assigned to hear such proceeding. The affidavit shall state the facts and the reasons for the belief that bias or prejudice exists, and shall be filed not less than ten days before the beginning of the term at which the proceeding is to be heard, or good cause shall be shown for failure to file it within such time. A party may file only one such affidavit in any case. It shall be accompanied by a certificate of counsel of record stating that it is made in good faith. 28 U.S.C. § 144.

Section 455, provides, in pertinent part:

- (a) Any justice, judge, or magistrate of the United States shall disqualify himself in any proceeding in which his impartiality might reasonably be questioned.
- (b) He shall also disqualify himself in the following circumstances:
 - (1) Where he has a personal bias or prejudice concerning a party, or personal knowledge of disputed evidentiary facts concerning the proceeding. 28 U.S.C. § 455.

parties that the judge observes in the course of the proceedings.” *Schreiber v. Kellogg*, 838 F.Supp. 998, 1003 (E.D.Pa.1993), *quoting Johnson v. Trueblood*, 629 F.2d 287, 291 (3d Cir.1980), *cert. denied*, 450 U.S. 999, 101 S.Ct. 1704, 68 L.Ed.2d 200 (1981)(citations omitted). An exception to the requirement that bias must stem from an extrajudicial source “requires disqualification when a judge displays ‘pervasive bias’ towards [the party seeking recusal] regardless of the source of the bias.” *United States v. Rosenberg*, 806 F.2d 1169, 1174 (3d Cir.1986), *cert. denied*, 481 U.S. 1070, 107 S.Ct. 2465, 95 L.Ed.2d 873 (1987).

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8. Recusal is inappropriate pursuant to Section 455, under which “[t]he applicable inquiry is whether a reasonable [person] knowing all the circumstances would harbor doubts concerning the judge’s impartiality.” *United States v. Vespe*, 868 F.2d 1328, 1341 (3d Cir.1989) (citations omitted); *see also United States v. Dalfonso*, 707 F.2d 757, 760 (3d

Cir.1985). “This rule is limited by the ‘extrajudicial source’ doctrine, which warrants a judge’s disqualification where the source of the partiality lies in knowledge gained outside the course of judicial proceedings.” *Viola v. United States*, No. 99-586, 2003 WL 147779, at *1 (E.D. Pa. Jan 21, 2003), *citing Liteky v. United States*, 510 U.S. 540, 554- 56, 114 S.Ct. 1147, 127 L.Ed.2d 474 (1994).

9. Even accepting the allegations of Plaintiffs’ Motion as true, they are insufficient as a matter of law. Plaintiffs make no statements or allegations based upon personal, or extrajudicial, bias. Thus, Plaintiffs fail to offer any facts or allegations that Judge Hardiman harbors personal or extrajudicial bias against them. Plaintiffs’ allegations relate to prior rulings and actions taken by Judge Hardiman in the course of its participation in this case. In no way can Judge Hardiman’s actions be construed to display a pervasive bias. Rather, as is demonstrated in the transcript of

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proceedings that Plaintiffs attached to their Motion, Judge Hardiman made extraordinary efforts to explain and guide Plaintiffs' counsel in rudimentary procedural aspects of federal court practice. Plaintiffs' counsel has refused to accept such guidance, engaging instead in a series ill-advised filings of motions, petitions and appeals which ironically have thwarted an expeditious resolution of Plaintiffs' claims.

10. The examples of the Judge Hardiman's alleged bias are inane or incorrect as a matter of law. For instance, Plaintiffs claim that the Judge manifested his alleged bias by personalizing his remarks at hearings by using "you" and "your" when referring to Plaintiffs' counsel but properly addressed Defendant's counsel. Plaintiffs' hyper-sensitivity on this point would not be sufficient to require recusal under Sections 144 and 455, and, in any event, the Judge at times addressed Defendant and Defendant's counsel as "you", as well as referring to Plaintiffs as Plaintiffs. See, e.g., Exhibit A to Plaintiffs' Motion, Transcript of March 10, 2005

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proceedings, p. 5, line 2, line 17; p. 7, line 8, line 13; p. 8, line 12-16, lines 22-25; and Exhibit B, Transcript of April 25, 2005 proceedings, p. 2, line 9p. 6, lines 24-25; p. 8, line 7.

11. Plaintiffs also complain that Judge Hardiman has not enforced the F.R.Civ.P. 26 initial disclosure requirement, which in the usual course would be required within 14 days of the rule 26(f) conference. However, Plaintiffs' improper appeals of the Court's interlocutory orders to the United States Court of Appeals for the Third Circuit warrants the abeyance of F.R.Civ.P. 26 disclosures. "It is well established that '[t]he filing of a notice of appeal ... confers jurisdiction on the court of appeals and divests the district court of its control over those aspects of the case involved in the appeal.'" *Sheet Metal Workers' Intern. Ass'n Local 19 v. Herre Bros., Inc.*, 198 F.3d 391, 394 (3d Cir.1999) (citing *Griggs v. Provident Consumer Discount Co.*, 459 U.S. 56, 58, 103 S.Ct. 400, 74 L.Ed.2d 225 (1982)) (footnote omitted).

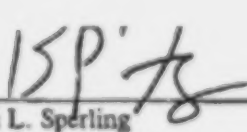
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12. All of the other examples of Judge Hardiman's so-called bias are likewise without merit. A review of such alleged biased actions demonstrate that they relate to prior rulings and actions made in the course of this case. Consequently, no reasonable person, knowing all the circumstances, would harbor doubts concerning Judge Hardiman's impartiality in this action.

13. As a result of Plaintiffs' failure to allege sufficient facts to prove that Judge Hardiman has a personal bias or prejudice against them, their Motion for Judicial Recusal must be denied.

WHEREFORE, Defendant Highmark Blue Shield respectfully requests that this Court enter an Order denying Plaintiffs' Motion for Judicial Recusal.

Respectfully submitted,


Gerri L. Sperling
Pa. I.D. No. 34603

Brian P. Fagan
Pa. I.D. No. 72203

SPRINGER BUSH & PERRY P.C.
Firm No. 271
Two Gateway Center, 15th Floor
Pittsburgh, PA 15222-1402

412-281-4900

Attorneys for Defendant Highmark Blue Shield

Dated: June 15, 2005

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF PENNSYLVANIA

DONNA SCHEIBLER and WILLIAM
SCHEIBLER, her husband,

Plaintiffs,

v.

HIGHMARK BLUE SHIELD,

Defendant.

No. 04-1928

Judge Hardiman

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NOTIFICATION OF CHANGE OF ADDRESS

TO: CLERK OF THE UNITED STATES DISTRICT COURT FOR THE WESTERN
DISTRICT OF PENNSYLVANIA

Please be advised that the contact information of counsel of record for Defendants Highmark
Inc. and Keystone Health Plan West d/b/a SecurityBlue has been changed as follows:

Gerri L. Sperling
Metz Lewis LLC
11 Stanwix Street, 18th Floor
Pittsburgh, PA 15222
(412) 918-1165

METZ LEWIS LLC

By:



Gerri L. Sperling
PA I.D. No. 34603

15

11 Stanwix Street, 18th Floor
Pittsburgh, PA 15222
412-918-1165
Attorneys for Defendants Highmark Inc. and
Keystone Health Plan West d/b/a SecurityBlue

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF PENNSYLVANIA

DONNA SCHEIBLER,

Plaintiff,

v.

No.

HIGHMARK BLUE SHIELD; and jointly
Separately, or severally, KEYSTONE
HEALTH PLAN WEST, d/b/a Security Blue,

Defendants.

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DEFENDANTS' NOTICE OF REMOVAL

**TO THE HONORABLE JUDGES OF THE UNITED STATES DISTRICT COURT FOR
THE WESTERN DISTRICT OF PENNSYLVANIA:**

PLEASE TAKE NOTICE that the Defendants Highmark Blue Shield and Kevstone Health

Plan West, d/b/a SecurityBlue, removes this action to the United States District Court for the
Western District of Pennsylvania on the following grounds:

1. This is an action filed and now pending in the Court of Common Pleas of Westmoreland
County, Pennsylvania. The action was instituted by Plaintiff's filing a Complaint in Civil Action on
or about October 4, 2005, which Complaint was docketed at No. 05-7642.

2. Defendants Highmark Blue Shield and Keystone Health Plan West were served with the
Complaint in No. 05-7642 on October 17, 2005, which is less than 30 days before the filing of this
Notice. A true and correct copy of the Complaint filed in the Court of Common Pleas of
Westmoreland County, Pennsylvania, at No. 05-7642 is attached hereto as Exhibit "A".

3. As set forth in her Complaint, Plaintiff seeks payment of medical expenses for medical
services provided to her husband under health coverage provided through Plaintiff's employer

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through an employee welfare plan. Although the Complaint purports to state claims under Pennsylvania law for specific performance, bad faith under 42 Pa.C.S.A. § 8371, unjust enrichment, and the Pennsylvania Unfair Trade Practices and Consumer Protection Law, this action relates to an employee welfare benefit plan under the terms and conditions of the Employee Retirement Income Security Act (ERISA), 29 U.S.C. § 1001, *et seq.*, and Plaintiff's state law claims are completely preempted by ERISA.

4. This Honorable Court has jurisdiction of this case pursuant to 28 U.S.C. 1331, 28 U.S.C. 1441, and 29 U.S.C. § 1132(a) and (e). 25

5. Defendants have this date given Plaintiff's attorney written notice of the filing of this Notice of Removal.

6. Defendants will also file a copy of this Notice of Removal and all related documents with the Prothonotary of the Court of Common Pleas of Westmoreland County as required by law.

WHEREFORE, Defendants respectfully request that this matter proceed in this Honorable Court as though originally commenced herein.

Respectfully submitted,

/s/ Gerri L. Sperling

Gerri L. Sperling
PA I.D. No. 34603

Kenneth S. Kornacki
Pa. I.D. No. 83739

METZ LEWIS LLC
11 Stanwix Street, 18th Floor
Pittsburgh, PA 15222
(412) 918-1100

Attorneys for Defendants Highmark Blue
Shield and Keystone Health Plan West, d/b/a
SecurityBlue 55

Dated: November 7, 2005

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF PENNSYLVANIA

DONNA SCHEIBLER and WILLIAM
SCHEIBLER, her husband,

Plaintiffs,

v.

HIGHMARK BLUE SHIELD,

Defendant.

No. 04-1928

Judge Thomas M. Hardiman

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**DEFENDANT'S MOTION TO CONSOLIDATE
WITH ACTION LISTED AT CASE NO. 05-1551**

Pursuant to Federal Rule of Civil Procedure 42(a), Defendant Highmark Blue Shield ("Highmark"), through its attorneys, hereby moves this Honorable Court to consolidate this action, listed at Case No. 04-1928, with the matter filed by Plaintiff Donna Scheibler and removed to the United States District Court for the Western District of Pennsylvania listed at Case No. 05-1551.

I. INTRODUCTION

In what can only be described as a brazen attempt to make an "end-run" around this Court's prior ruling that dismissed the statutory "Bad Faith" claim as preempted under the Employee Retirement Income Security Act ("ERISA"), Plaintiff Donna Scheibler filed a second action in Pennsylvania state court in which she again raises the same claims of statutory bad faith against Highmark. Because the counts raised in the second action are also preempted by ERISA, Highmark removed the action to this Court, which action was assigned to Judge Hardiman and is now listed at Case No. 05-1551. With the second action now removed, the interests of justice and judicial

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economy require that the two actions, which are based on the same set of operative facts and allegations, be consolidated for purposes of dispositive motions and ultimately, trial.

II. PLAINTIFFS' ACTION AT CASE NO. 04-1928 ALLEGED AN ERISA VIOLATION BASED ON HIGHMARK'S ALLEGED WRONGFUL REFUSAL TO PAY FOR MEDICAL TREATMENTS

1. Plaintiffs Donna Scheibler and William Scheibler commenced the action listed at Case No. 04-1928 (the "First Action") by filing a two-count Complaint against Highmark in this Court on December 23, 2004.¹ This action was assigned to the Honorable Thomas M. Hardiman. 19

2. In the First Action the Plaintiffs alleged a violation of ERISA, 29 U.S.C. § 1132(a)(1)(B) (Count I) and violation of Pennsylvania's Bad Faith Statute, 42 Pa.C.S.A. § 8371 (Count II). A true and correct copy of the First Complaint, without exhibits, is attached hereto as Exhibit A.

3. The First Complaint alleges that Donna Scheibler is an employee of ABB, Inc. ("ABB") and that she is enrolled as a beneficiary of ABB's health care benefits plan (the "Plan"). Plaintiffs further allege that her late husband, William Scheibler ("William") was entitled to benefits under the Plan. See First Complaint ("First Compl.") ¶ 4.

4. Plaintiffs allege that "[a]t all times relevant hereto, [Highmark] provided health care insurance pursuant to an employee benefit plan on behalf of the Plaintiff, Donna Scheibler." *Id.* ¶ 7.

5. According to the First Complaint, William was diagnosed with cancer for which he underwent radiation treatment in 1997. *Id.* ¶ 8. William's treating physician indicated that oral 15

¹ William Scheibler died in 2005 after the First Action was commenced. Neither William nor his estate is listed as a Plaintiff in the Second Action.

surgery was medically necessary to treat William's "radiation induced caries" condition, as a result of the radiation treatments administered for his cancer. Id. ¶ 9.

6. Plaintiffs claim that Highmark approved pre- and post-operative hyperbaric oxygen treatments to be performed in anticipation of William's oral surgery, but denied payment for the surgery itself. Id. ¶¶ 10-11. William proceeded with his surgery, negotiating a payment to the hospital that was far less than the actual billed charges set forth on later billing statements. Id. ¶ 16.

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7. Plaintiffs seek to recover from Highmark damages they allegedly suffered as a result of Highmark's denial of benefits under the Plan to cover the costs of William's surgery.

8. On January 13, 2005, Highmark moved to dismiss Plaintiffs' cause of action for bad faith pursuant to Pennsylvania's Bad Faith statute, 42 Pa.C.S.A. §8371 (Count II) as completely and expressly preempted by §§ 502(a) and 514(a) of ERISA, 29 U.S.C. §§ 1132(a) and 1144(a).

9. On February 1, 2005, this Honorable Court entered a Memorandum Opinion whereby it granted Highmark's Motion to Dismiss. The Court held that Plaintiffs' count under the Pennsylvania Bad Faith Statute was "plainly barred under controlling law" and dismissed Count II of the First Complaint **with prejudice**. A true and correct copy of the Court's Memorandum Opinion and Order is attached hereto as Exhibit B.

10. The First Action is still pending before this Court on the lone, remaining count under ERISA (Count I).

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III. DONNA SCHEIBLER FLOUTS THIS COURT'S ORDER OF DISMISSAL BY FILING A SECOND ACTION IN STATE COURT ALLEGING A CLAIM FOR BAD FAITH

11. On October 4, 2005, Donna Scheibler filed a Complaint against Highmark and Keystone Health Plan West, d/b/a Security Blue ("Keystone"), in the Court of Common Pleas of Westmoreland County, Pennsylvania (the "Second Action"). A true and correct copy of the Complaint filed in the Second Action is attached hereto as Exhibit C.

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12. Highmark and Keystone removed the Second Action to this Court on November 7, 2005, on the grounds that the Second Complaint was again based on the alleged denial of benefits and raised issues of ERISA preemption. Like the First Action, the Second Action was assigned to Judge Hardiman at Case No. 05-1551.

13. Although this Court previously dismissed, with prejudice, her count for bad faith under 42 Pa.C.S.A. §8371, Scheibler included the same count against Highmark in the Second

Complaint. Scheibler also alleged counts for Specific Performance, "Dereliction of Duty to Deal in Good Faith," Unjust Enrichment, and Violation of Pennsylvania's Unfair Trade Practices and Consumer Protection Law.

14. Like the ERISA count in the First Action, all of the alleged counts in the Second Complaint arise from Highmark's alleged wrongful refusal to pay for William's surgery, and are grounded in the same set of operative facts as the First Action.

15. A plain reading of the Second Complaint confirms that many of the factual allegations that serve as the basis of the First Complaint were simply repeated in the Second Complaint. For example, Plaintiff alleges in the Second Complaint:

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- a. Donna Scheibler, as an employee of ABB, Inc., is enrolled as a beneficiary of the company's health care benefits plan. Plaintiff's family is entitled to the benefits of the health care plan. Second Compl. ¶ 4; (First Compl. ¶ 4).
- b. Scheibler selected Highmark Blue Shield, from several offered to ABB employees, and makes co-payments with her employer. Second Compl. ¶ 5; (First Compl. ¶ 5).
- c. Highmark and/or Keystone Health Plan West provided health care insurance pursuant to employee benefit plans on behalf of Scheibler. Second Compl. ¶ 7; (First Compl. ¶ 7).
- d. Highmark covered and paid medical expenses related to Mr. Scheibler's cyst, a heart attack and stroke, tonsillar carcinoma and a radial dissection in 1997. Second Compl. ¶ 32 (First Compl. ¶ 8).
- e. Mr. Scheibler's treating physicians wrote letters to Highmark stating that his need for oral surgery was medically necessary. Second Compl. ¶ 34; (First Compl. ¶ 9).
- f. Highmark approved payment of Mr. Scheibler's pre-op and post-op, Hyberbaric Oxygen hospital treatments, done in preparation for surgery. Second Compl. ¶ 37; (First Compl. ¶ 10).
- g. Highmark denied payment for Scheibler's surgery, schedule March 2004, in May 2004. an egregious delay, as the untimely denial based on unspecified

language. Second Compl. ¶ 41; (First Compl. ¶¶ 11, 13).

16. Count One of the Second Complaint seeks specific performance, which in effect, seeks payment of benefits under an ERISA plan, just as Defendants seek in their remaining count of the First Action presently pending before Judge Hardiman.

17. Highmark's time to respond to the Second Complaint has not elapsed as of the date of this Motion. However, Highmark intends to move to dismiss all counts, including the count for bad faith under 42 Pa.C.S.A. §8371, on the grounds of ERISA preemption.

IV. PLAINTIFFS' ACTIONS AGAINST HIGHMARK, WHICH ARE GROUNDED IN THE SAME OPERATIVE FACTS, SHOULD BE CONSOLIDATED IN THE INTERESTS OF JUSTICE AND JUDICIAL ECONOMY

18. Federal Rule of Civil Procedure 42(a), titled "Consolidation," provides: "[w]hen actions involving a common question of law or fact are pending before the court, it may order a joint hearing or trial of any or all the matters in issue in the actions; it may order all the actions consolidated; and it may make such orders concerning proceedings therein as may tend to avoid unnecessary costs or delays."

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19. Consolidation has been held to be appropriate when the two pending actions arise out of the same facts and seek the same basic relief. See Francesco v. White Tiger Transportation Company, Inc., 679 F.Supp. 456, 458 (M.D. Pa. 1988) (negligence action filed by the wife/passenger against trucking company charged with causing accident consolidated with earlier action filed by husband/driver).

20. Consolidation under Rule 42(a) is a "procedural device designed to promote convenience and economy in administration while avoiding duplicative litigation." Id.

21. Here, the interests of judicial economy and avoidance of what would clearly be duplicative litigation strongly support consolidating the two actions Plaintiffs have filed against Highmark. Both actions arise from Highmark's alleged wrongful denial of the payment for Mr. Scheibler's oral surgery. Evidence of the similarity of the two actions is found in the fact that many of the allegations Plaintiffs made in the First Complaint were simply repeated in the Second Complaint (see ¶ 15, infra).

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22. Because of the similarity of the allegations and issues raised in the two actions, all of the discovery and trial issues in the actions will involve the same facts, time periods and witnesses. It would be wasteful and repetitive to require discovery to proceed on two separate fronts and would further be a misuse of judicial time and resources to require two separate trials on the two actions.

23. Second, because the causes of action raised in the Second Action are based on the same operative facts alleged in the First Action, and seek similar if not identical relief, the Second Action raises similar issues of ERISA preemption that this Court previously addressed and disposed of in the First Action. 70

24. Third, and perhaps the most compelling reason to consolidate these actions, is the fact that Plaintiffs are obviously attempting to by-pass this Court's prior Order that dismissed the statutory bad faith count raised in the First Action by filing the Second Action. Count III of the Second Complaint raises the identical claim under 42 Pa.C.S.A. §8371 that this Court dismissed in

its Order dated February 1, 2005. In fact, Paragraphs 69 and 70 in Count III of the Second Complaint are verbatim reproductions of paragraphs 26 and 27 of the bad faith count that was dismissed from the First Action. Plaintiffs should not be able to manipulate the legal system in this manner, and consolidating the actions would serve to prevent such further tactics.

WHEREFORE, Defendant Highmark Blue Shield respectfully requests that this Court enter an Order consolidating this action with the action listed at Case No. 05-1551. 69

Date: November 9, 2005

Respectfully submitted,

METZ LEWIS, LLC

By: /s/ Kenneth S. Kornacki

Gerri L. Sperling, Esquire

Pa. I.D. No. 34603

Kenneth S. Kornacki, Esquire

Pa. I.D. No. 83739

11 Stanwix Street, 18th Floor
Pittsburgh, PA 15219

Phone: (412) 918-1100

Fax: (412) 918-1199

Attorneys for Defendant
Highmark Blue Shield

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